GMC Files

Dr Barton
2000/2047
Hampshire Constab
Vol 1

2000/2047 Hampshire Constab

Document	
Screening decision form	
Letters from Hampshire Constabular allegations of unlawful killing	
Witness Statement of Lesley Lack da	
Witness Statement of Gillian Mackenzie dated 06/03/00	Gladys Richards
Letter from GMC to Dr Barton inviting her to appear before IOC on 21/06/01	Gladys Richards
Letter from GMC to Dr Barton confirming IOC determination that not necessary to impose conditions	Gladys Richards
Note that Dr Barton will not be charged in relation to Gladys Richards' death. Police will be investigation another 9/10 suspicious deaths.	Various
Letter from police to GMC (06/02/02) confirming no further police investigations are appropriate unless further substantial evidence becomes available	Various
Police statement of Dr Barton	Gladys Richards
Expert report of Professor Ford	Richards, Cunnigham, Wilkie, Wilson, Page
Expert report of Professor Livesley	Gladys Richards
Expert report of Dr Mundy	Cunnigham, Wilkie, Wilson, Page
Letter from GMC to Dr Barton inviting her to appear before IOC on 21/03/02	
Transcript of IOC hearing on 21/03/02 - no order made	
Letter of complaint from Bernard Page to GMC (17/05/02) re death of his mother	Eva Page
Letter from Gillian MacKenzie to GMC re concerns regarding conduct of medical staff	Gladys Richards
Letter from Charles Farthing to GMC re death of his step father, Mr Cunnigham	Arthur Cunnigham
Letters from Iain Wilson to GMC re death of his farther,	Robert Wilson

Dr Barton
GMC Files Reviewed by KVK on 12/02/07

2000/2047 Hampshire Constabulary v Dr Jane Barton, Volume 1 (of 2)

Document	Relates to
Screening decision form	
Letters from Hampshire Constabulary to GMC re allegations of unlawful killing	Gladys Richards
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Witness Statement of Gillian Mackenzie dated 06/03/00	Gladys Richards
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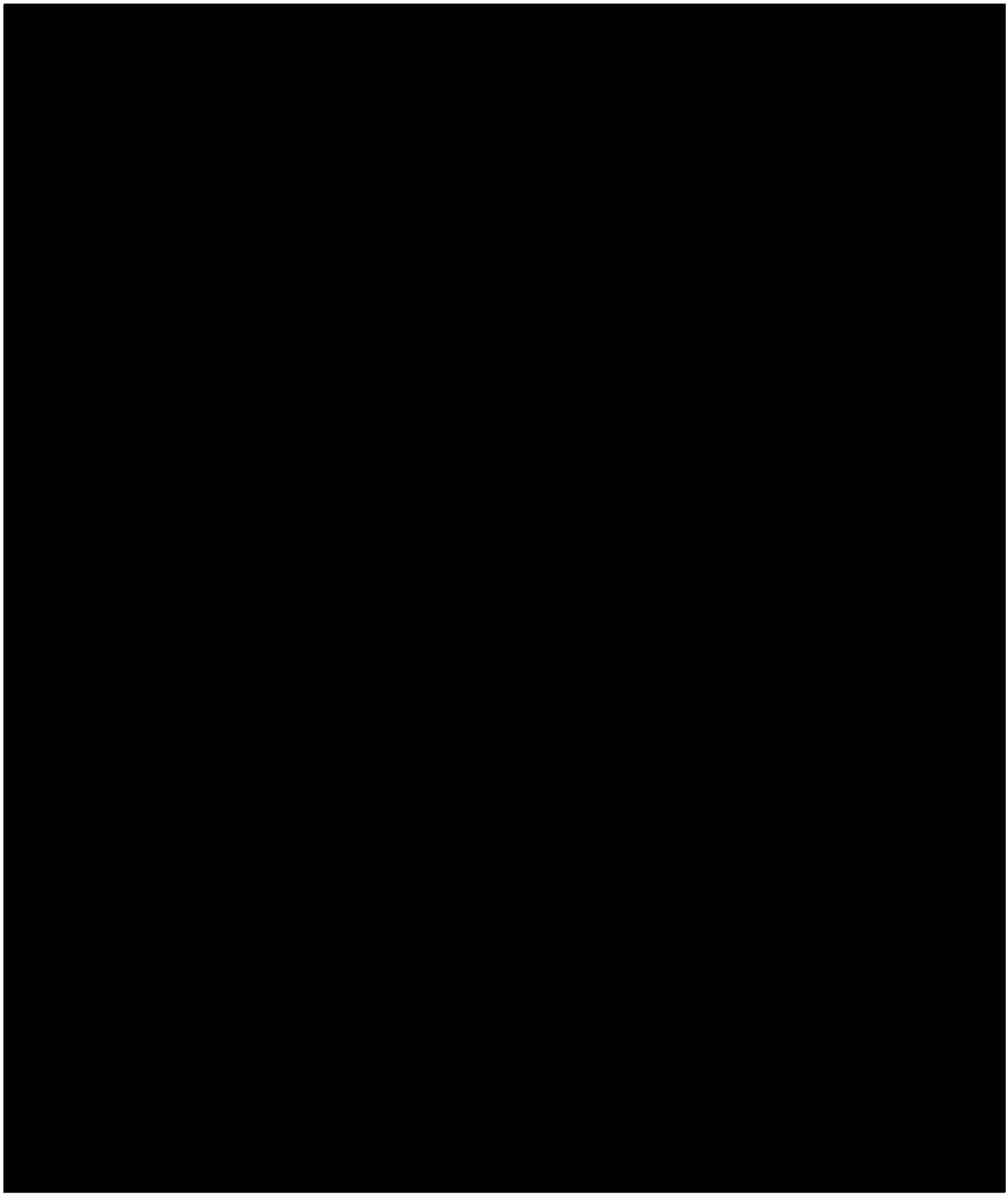
Letters from Iain Wilson to GMC re death of his farther,	Robert Wilson

Robert Wilson	
Letter from GMC to Dr Barton informing her of PPC on 29-30/08/02	Page, Wilkie, Richards, Cunningham, Wilson
Investigation into the Portsmouth Healthcase NHS Trust Report	
Dr Barton's written response to PPC allegations	Page, Wilkie, Richards, Cunningham, Wilson
Sub File: 2002/1608 CHI v Unknown:	
Letter from Mrs Batson to PCT complaining of care of mother, Mrs Valma Gilbertson	Velma Gilbertson
Response from PCT to Mrs Batson	Velma Gilbertson



Michael Keegan Assistant Registrar
Conduct Case Presentation Section FPD
General Medical Council
178,Great Portland Street
London W1W 5JE

Dr JA Barton

Code A

Your Reference MK/2000/2047

14th September 2002

Dear Sir,

Conduct Case Presentation Section FPD

I acknowledge receipt of the letter reference quoted above.

I will be unable to attend a hearing between the dates 11th-22nd December 2002 as I have a holiday booked at that time.

Yours Faithfully

Code A

Dr Jane Barton

RECEIVED
18 SEP 2002

RECEIVED
18 SEP 2002

Memorandum

Ref: **2000/2047**
To: **Dr Lewis**

Out

From: **Michael Hudspith**
Code A

Date: **12 February 2002**

Dr Jane Ann BARTON (1587920) BM BCH 1972 Oxfd

Identification and previous history

Positively identified. No previous history.

Background

Dr Lews last saw this case back in June 2001 when he was asked to consider referral of this case to the IOC. A copy of the IOC item is at Flag A with a transcript of proceedings at Flag B. The Committee decided to make no order.

At the time the case was considered by the IOC the police were only investigating 1 death, that of Gladys Richards. The investigation was subsequently widened and, although a decision was eventually taken not to pursue any charges in respect of Mrs Richards' death, 4 other deaths were considered. They were:

Arthur 'Brian' Cunningham
Alice Wilkie
Robert Wilson
Eva Page

We have now been informed that no criminal charges will be brought against any doctor (Flag C). However the police feel the case raises issues for the GMC and have accordingly forwarded expert reports from Professor Lord (Richards, Cunningham, Wilkie, Wilson & Page), Professor Livésley (Richards) and Dr Mundy (Cunningham, Wilkie, Wilson & Page) - see Flags D, E & F.*

Discussion

Whilst acknowledging the decision not to pursue criminal charges, before closing our file, we must first satisfy ourselves that there are no outstanding issues of professional misconduct or deficient performance on Dr Barton's part which may warrant formal action under the Council's fitness to practise procedures.

The two matters for the screener are

1. SPM or SDP?

In their reports, each expert highlight the possibly inappropriate nature of Dr Barton's prescribing of opioid analgesics as a cause for concern. Given the number of instances of inappropriate prescribing it may certainly be argued that there is a clearly identifiable pattern of deficient performance on Dr Barton's part. However, I would perhaps be uneasy with this approach given Professor Ford's use of phrases such as 'highly inappropriate', 'potentially hazzardous' and 'reckless' and would be inclined to recommend the case be pursued under conduct. I would appreciate guidance from the screener.

2. IOC

At the original IOC meeting the Committee could only consider information relating to the death of Mrs Richards and were not assisted by any 'expert opinion' save that of Dr Barton's own police statement. In light of both the further 4 cases and additional information recently received from the police in the form of expert reports, does the screener consider that the circumstances of the case now warrant referral back to the IOC?

I appreciate that the screener is not currently privy to all the available 'documentary evidence'. The reports compiled by Professors Ford and Livesley and Dr Munday are of course summaries and based on individual interpretation of statements and medical records. We have recently written to police to requesting full disclosure of their papers. Should the screener consider sight of any of these additional documents necessary prior to making a recommendation

I attach forms SDF 4 & 5 for completion.

Code A

* You will note that the letter at Flag C also makes reference to Dr Althea Lord. Dr Lord was a Consultant Geriatrician at Gosport War Memorial Hospital who had overall responsibility for the medical care of the 5 patients in question, although day to day medical care was delegated to the clinical assistant, Dr Barton.

In contrast to Dr Barton, Dr Lord does not appear to have been the subject of any explicit criticism by the 'experts' and, as such, I do not feel that IOC referral need be considered in her case. I would, however, appreciate the screener's views.

medical sweep:

Professor Ford's analysis of the detail of this case raises sufficient grounds to refer to IOC and for the case to progress under the Conduct procedures rather than performance. I have completed the checklist,

8

Medical Screening Memo: Dr Malcolm Lewis

Case: 2000/2047
Doctor: Barton
Date: 11th June 2001

The allegations made in the statement of Lesley Lack raise issues of SPM. The allegation is that a decision was made to treat a post-operative haematoma by palliative pain relieve with use of a morphine syringe driver. There was no further plan to approach the problem by a surgical review. This approach would seriously test the boundaries of the doctrine of 'double effect' and I note that Hampshire Constabulary are pursuing an inquiry of unlawful killing.

The case must be heard at PPC, but should initially be tested at IOC, in view of the seriousness of the allegations.

Code A

Memorandum

Ref: **2000/2047**
To: **Dr Lewis**

From: **Jackie Smith**
Code A

Date: **12 June 2001**

Out

Information received from Hampshire Constabulary concerning Dr Jane Ann Barton (1587920) BM BCh 1972 Oxford

1. We received information from Hampshire Police last July stating that they were investigating the death of Gladys Richards at the Gosport Warn Memorial Hospital.

2. We have now received further information from the police, and I would ask you to consider whether this case meets the threshold for referral to the IOC.

Code A

12/06/01

I asked Dr Lewis to screen this case on the basis of the information provided to us by the police dated 6/6/01. Dr Lewis returned the file to me, after screening, and said that he had screened the case on the basis of what was provided by the police on 6/6/01.

Code A

File note of telephone conversation.

I had a lengthy conversation with Dr Arthurs at RO about Dr Barton. She said she wanted to provide a further briefing to ministers about the case. I said that I had no further information from that which I gave Mike Gill a couple of weeks ago. I stressed that we were awaiting information from the police, and that once received, we would seek a screener's view on whether it met the threshold for referral to IOC. I reiterated that much of the information we had was strictly confidential and that as far as we knew the police was still limiting their investigations to 1 suspicious death. I said that we would keep her fully informed as and when further information became available.

Code A

Jackie Smith
22 May 2001.

- Isabel asked me to ring the police to find out the outcome of the meeting scheduled for 21/5/01. I rang Det Sgt. Ray Burt (25/5) who was unavailable but I left a message for him to contact me.

Code A

[redacted]

[redacted]

[redacted]

Legal Professional Privilege LPP

[redacted]

[redacted]

Barton's
questions
dea
at
We

[redacted]

[redacted]

File note of telephone conversation.

I spoke with Regional Director of Public Health, Dr Mike Gill, and informed him, in outline only, of the developments and promised to keep him updated.

He said that Dr Yvonne Arthurs was dealing with the matter, and her number is Code A

Code A

Jackie Smith
10 May 2001.

[redacted]kie Smith (7344 3753)

From: Isabel Nisbet Code A
Sent: 10 May 2001 11:24
To: 'Liz McAnulty'
Cc: Sarah Bedwell Code A ; Jackie Smith Code A
Subject: RE: Robin Herron

Liz:

Our contact here is Jackie Smith Code A Otherwise, speak to Sarah Bedwell Code A The police are very cagey about how much can be said (NB NO disclosure to the doctor yet, on police instructions). The numbers which Robin mentioned were in local press reports.

Isabel

-----Original Message-----
From: Liz McAnulty [mailto: Code A
Sent: 09 May 2001 15:44
To: Code A
Subject: Robin Herron
Importance: High

Dear Isabel
I've just had a meeting with Robin (what a nice man!). He said you had contacted him about a doctor who may have been involved with a large number - possibly 600 - premature patient deaths. He said the police had been in contact with us as there were wider issues, possibly involving nurses. Do you have a contact I can get in touch with as we don't seem to have heard anything yet.

Best wishes

Liz

[redacted]

File Note: 2000/2047

(Stephanie Day enquired about this case following a call from the press asking about this doctor.) I rang DCI Burt who gave the following summary of the investigation:

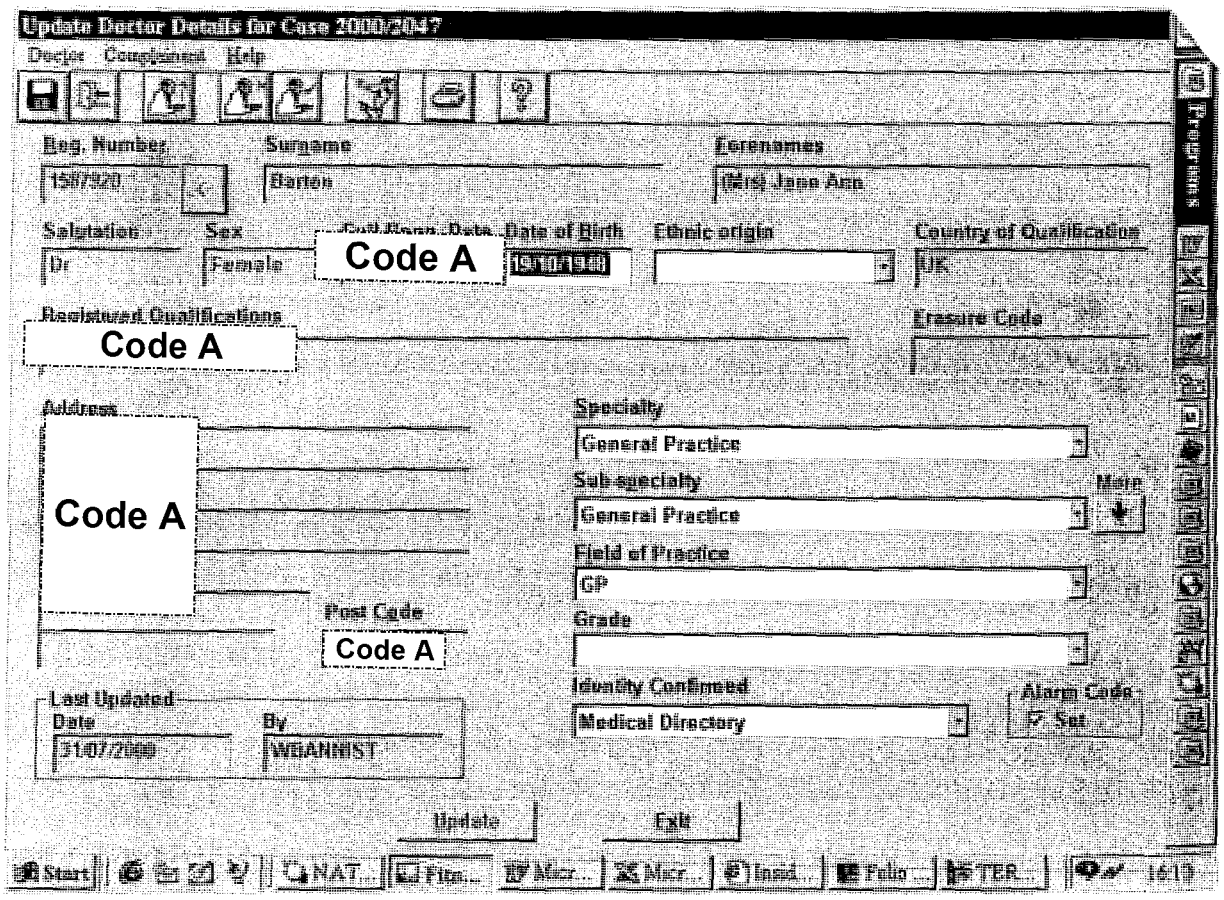
Gladys Richards died 21 August 1998 at Gosport War Memorial Hospital (has facilities for elderly, no resident doctors, care provided by external GPs etc). Ms Richards had returned to the hospital for the second time to recuperate from a further fall (the first time involved a broken hip).
In September 1998, one of her daughter's raised allegations of unlawful death and the matter was referred to local police in Gosport, who concluded their investigation in March 1999, having found a lack of evidence to support the allegations. The daughter complained to the Police Complaints Authority and the matter was referred to DCI Burt in mid-1999 to be re-examined.
Dr Barton and various nurses were interviewed under caution, medical records were obtained along with an expert opinion. The case was passed to the CPS and DCI Burt will be chasing them tomorrow for a progress report/decision.

I explained our IOC powers and the information we need asap to determine whether interim orders should be considered. DCI Burt understood the need to act quickly and I agreed to fax my request so that he can refer it on if necessary. He would also be happy for us to visit and go through their paperwork. I asked him about the press cuttings which refer to other similar allegations. He confirmed that they have received several enquiries but have not yet instigated any further investigations and are unlikely to do so until they are notified of the CPS' decision in the original case. It is also unclear as yet whether the other concerns relate to the same doctor.

Contact details:
DCI Ray Burt
Hampshire Constabulary
Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB
Tel: 0845 045 45 45
Code A

Code A 11 April 2001

Stephanie Day has spoken to the Police Media Services Dept., who believe that Dr Barton has recently left her job, but we have no further details.
Code A 11/4.



No pps
WB 31/7/00.

Isle of Wight, Portsmouth and South East Hampshire
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Code A

Our Ref: PO/JD/021302jb.doc

13 February 2002

Private & Confidential
Dr Jane Barton

Code A

Dear Dr Barton

Following our meeting last night I wish to set out the basis of our agreement. I have shared this letter with Dr Ian Reid since it relates, in part, to the Gosport War Memorial Hospital.

- We agreed that you would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital.
- We agreed that you would voluntarily stop prescribing opiates and benzodiazepines with immediate effect.
- We were unable to put a timescale on these restrictions but agreed to review the situation monthly.

In view of the anticipated press interest, the Health Authority and Portsmouth HealthCare NHS Trust have prepared a draft statement which we have attached for your perusal.

Many thanks for your co-operation.

Yours sincerely

Code A

p p. Dr Peter Old
Acting Chief Executive
Code A

Attachment

Isle of Wight, Portsmouth and South East Hampshire
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Switchboard: 023 9283 8340
Direct Dial: Code A

From Fax Number: 023 9283 5197

STRICTLY PRIVATE & CONFIDENTIAL FAX TRANSMISSION

TO:	Michael Hudspith	
TO FAX NUMBER:	Code A	**DATE:** 15 March 2002
FROM:	Dr Peter Old	**PAGE 1 OF** 3

If you do not receive all pages of this fax, please phone 023 9283 5000 immediately
Thank you

MESSAGE:

As per our telephone conversation please find attached letters to Dr Jane Barton.

Regards

Peter Old

Isle of Wight, Portsmouth and South East Hampshire
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Code A

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Many thanks for your co-operation.

Yours sincerely

Code A

p.p. Dr Peter Old
Acting Chief Executive
Email Address: Code A

Attachment

Isle of Wight, Portsmouth and South East Hampshire Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Code A

Our Ref: PO/JD/031502jb.doc

15 March 2002

Private & Confidential
Dr Jane Barton

Code A

I wrote to you on 13 February 2002 setting out our agreement on restrictions to your medical practice. At that time it was not possible to put a timescale on these restrictions, but we agreed to review the situation monthly.

I understand that you are due to appear before the GMC in the very near future. Therefore I propose that we continue with the current restrictions until we have the result of the GMC's deliberations.

Thank you for your continued co-operation.

Yours sincerely

Code A

Dr Peter Old
Acting Chief Executive
Email Address: Code A

cc: Michael Hudspith, GMC

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
14 March 2002

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Freephone: 0800
Telephone: 020 7202 1500
Fax: 020 7202 1663

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

Mr Adam Elliott
Committee Co-ordinator
Interim Orders Committee Secretariat
General Medical Council
178 Great Portland Street
London, W1W 5JF

Dear Adam

Interim Orders Committee 09:30 on 21st March 2002

I write with reference to your letter to my client Dr Barton of 12th March and the forthcoming hearing before the Interim Orders Committee at 9.30am on 21st March 2002. Can I confirm through this letter that I act on her behalf, and that she will be represented by me and by Mr Alan Jenkins of Counsel at the forthcoming hearing.

Please do not hesitate to contact me if I can be of further assistance.

Yours sincerely

Code A

D1

PORTSMOUTH
HealthCare
NHS
TRUST

Consultant Geriatricians
Specialist Registrars
Professor Severs
Ward Managers Jersey House/George ward/Jubilee House/Briarwood ward/ Shannon ward/Cedar ward/Daedalus ward/[redacted]
Chrissie Immins & Medical Secs

Our ref
DJ/LB
Your ref

Date
16 February 2000
Ext
Code A

Dear Colleague

The bed crisis at Queen Alexandra hospital continues unabated. Routine surgical operations have been cancelled now. It has fallen on us to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some underutilisation 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. We shall trial the flexible use of the beds for a few weeks and I would be happy to co-ordinate any comments.

Thank you for your help.

Yours sincerely

Code A

DAVID JARRETT FRCP

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

Queen Alexandra Hospital
Cosham, Portsmouth, Hants PO6 3LY

Exc 2

EMERGENCY USE OF COMMUNITY HOSPITAL BEDS

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. Some continuing care beds remain underutilised in Petersfield Community Hospital, Gosport War Memorial Hospital and St Christopher's Hospital Fareham. These beds have no resident medical staff and weekly, or less than weekly, Consultant ward rounds. There is basic nursing care and only minimal rehabilitation staff and facilities.

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

1 Waiting for placement having had a full care management assessment
2 Medically stable with no need for regular medical monitoring
3 No outstanding investigations or need for close medical or nursing monitoring
4 No interventional therapy such as intravenous lines or need for IV medication
5 The patient lives near the community hospital and/or are willing to go there for temporary placement awaiting permanent placement
6 The patient and family consent to the move
7 The patient, family and staff of referring ward clearly understand that the placement is in a post acute bed, not continuing care bed; this placement does not entitle patient to NHS continuing care
8 GP beds in community hospitals are independent of the department's continuing care provision and their flexible use should be negotiated with the patient's general practitioner

This policy will be operational from 16.2.00 and will be reviewed after one month. Linda Butchers in the Elderly Medicine Offices will keep a list of names of patients from referring ward and consultant, discharge destination and any problems encountered.

g:\linda\dj\comm.hosp.beds\9.2.00

Dr David Jarrett
Elderly Medicine
Portsmouth Healthcare Trust

Dr Jane Barton
Clinical Assistant in Elderly Services
The Surgery
148, Forton Road
Gosport
HANTS PO123HH
Tel 02392583333
22nd February 2000

CLINICAL ASSISTANT ELDERLY MEDICINE GOSPORT WAR MEMORIAL HOSPITAL

I was very disappointed and also quite concerned to be shown a letter from yourself dated the 16th 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 understilisation in a unit which is handling approximately 40% or the continuing care dontby Elderly Services at this time.

I hope you will give this serious consideration,

Yours Sincerely

PORTSMOUTH
HealthCare
NHS
TRUST

Dr Jane Barton
Clinical Assistant
Elderly Medicine
Gosport War Memorial Hospital
Gosport
Hants

DJ/MW

07 March 2000

Code A

Dear Jane

RE: CLINICAL ASSISTANT ELDERLY MEDICINE GWMH

Thank you for your letter dated from the 22nd February making me aware of your concerns about the use of continuing care wards.

My original letter was an attempt to ease some of the acute pressures at Queen Alexandra Hospital. As you know there are a huge number of elderly patients as outliers who are blocking the surgical beds. There has effectively been little elective surgery from the Christmas crisis period.

A brief survey, a few weeks ago showed that there were some continuing care beds that were unfilled.

After discussion between John Bevan and my consultant colleagues, we felt it might help the dire situation here if we used some of those unfilled continuing care beds for patients who are clinically stable and awaiting placement in say a rest home or nursing home. It was envisaged that the patients would require little medical input and that we would only move patients who they themselves and their families were happy to the move.

I understand that the continuing care workload at Gosport War Memorial Hospital is quite large certainly in comparison with other community hospitals. Gosport is busy in other areas with an ever increasing number of referrals from Haslar hospital and an increasing need for consultant input to the GP beds. With that in mind we will need to look at ways of trying to improve consultant cover for the Gosport peninsula. I will try and incorporate this into our plans to try and expand consultant numbers.

Thank you for letting me know of your concerns.

Yours sincerely

Code A

David Jarrett

E:\C\PPC\Forms\AttendS.doc

IOC Attendance Sheet E

Doctor present and represented by Counsel/QC

Dr Barton is present and is represented by Mr Jenkins, Counsel, instructed by the Medical Defence Union.

Mr Lloyd, Counsel, instructed by the Solicitor to the Council, represents the Council.

Enclosure (2)

Peter King
Personnel Director
Portsmouth Healthcare trust
St James Hospital
Portsmouth PO48LD

Dr.JA Barton
Clinical Assistant in Elderly Services
148, Forton Road
Gosport
Tel 023 92583333
28th April 2000

References:
a. My letter 28.1.2000 to Clinical Director Elderly Medicine
b. My letter 22.2.2000 to Dr David Jarrett (copies of both letters attached)

Dear Peter,

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.

My original contract of employment signed in 1993 indicates I am required to give you two months notice. However, I wish my serious concerns and anxieties to be placed on record during the notice period.

Yours sincerely,

Jane Barton

Copies to:
M Millett
Dr I Reid
Dr A Lord

PORTSMOUTH
HealthCare
NHS
TRUST

Private & Confidential

Dr J Barton
The Surgery
148 Forton Road
GOSPORT
PO12 3HH

Our ref
FC/LD
Your ref

Date
19 May 2000
Ext
Code A

Dear Jane,

I have been passed a copy of your letter of 28th April 2000 tendering your resignation from the post of Clinical Assistant in Elderly Services at Gosport War memorial, to which I believe Peter King has formally responded.

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.

Acceptance of the above pressures coupled with your resignation has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising. The paper proposes enhanced medical input and rationale for that, which is in keeping with current intermediate care discussions.

I hope that you will be able to give your support to this proposal, given your knowledge of the current situation, when the paper is presented to the PCG.

My thanks for your contribution to Gosport War Memorial Hospital and my good wishes for continued success in your other roles.

Yours sincerely

Code A

Fiona Cameron
Divisional General Manager

Code A

GUIDELINES FOR ADMISSION TO DAEDALUS WARD

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday 21 March 2002

Case of
BARTON, Jane Ann [*Conduct Case*]

T. A. REED & CO

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.

A 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,

> B "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".

C 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.

D 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.

> E "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
> F 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:

> G "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".

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

A

> "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.

B

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

C

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,

D

> "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,

E

> "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

F

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

G

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".

H

That deals with the reports of those three experts.

A 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.

B 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.

C 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.

D 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.

E 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.

F 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

G 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*

H *instructions*] I have no instructions on any other action taken against Dr Lord.

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

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

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

JANE ANN BARTON, Sworn
Examined by MR JENKINS

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

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

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

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

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

A

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.

B

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.

C

Q How many other doctors would be there throughout the day to treat these 48 patients if all the beds were full?
A None.

D

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.

E

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.

F

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.

G

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

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

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

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

Q What you have told us is that, over time, the level of dependence of the patients increased.
A It escalated enormously: to the point where I began to be saying to my employers, "I can't manage this level of care for this number of patients on the commitment I have". But there was not anybody else to do it. During 1998, when the consultant on Dryad went on 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 that it?
A Which you carry in your coat pocket. [*indicates document*]

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

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

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

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

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

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

A 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 B 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 C 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 D 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 – E 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 F 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 G 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?
H 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

A 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?

B

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
C 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
D 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
E 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
F 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----
G 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.

H Q Did you feel that your relationship with the nursing staff was such that such informal communication could take place?
T A Reed & Co A I trusted them implicitly. I had to.

A 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 B 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 C 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".

D 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 E 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 F 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.

G 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.

H Q ...in the cottage hospital.

A No.

A 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.

B 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",

C – 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?
D 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
E 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?
F A Yes.

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

G 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
H significantly higher volume of patients to your cottage hospital and with much higher levels of dependency?

A 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.

B 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?

C 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.

D 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".

E A Yes.

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

A Yes.

F 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.

G 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

H us", he says,

A "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,

B "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".

C 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:

D 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
E 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.

F 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.

G 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
H acceptable standard, which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition, my

staff are subjected to ever-increasing pressures from patients and relatives, causing stress and sickness levels to rise.

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

The next document in time is a letter from Dr Jarrett dated 7 March, by way of response. I do not need to read it to you, but you have heard Dr Barton suggest that there was a request, effectively, for three quarters of a million pounds from the primary care group to go towards the local hospital. You may find a hint of that in the last paragraph of this letter.

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

"Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport War Memorial Hospital. I have highlighted these worries on two occasions previously in the enclosed letters.

I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example, on one of the wards I will only be having locum consultant cover until September. In addition, an increasing number of higher risk 'step down' patients continue to be transferred to the wards, where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.

The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation".

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

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

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

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

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

THE LEGAL ASSESSOR: I have no questions, sir.

Questioned by the COMMITTEE

DR RANSON: Did you have consultant cover during 1998?
A I had a lady called Dr Jane Tandy, who became 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

A 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.

B 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
C 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.

D 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.

E 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.

F 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.

G 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.

H Q Were there any audit meetings in the hospital?
A I did not go. I was not invited to go to audit meetings.

Q Turning to page 380, I would also like some clarification. It implies in the first bullet point there that there is still some relationship to the Gosport War Memorial Hospital. What was the continuing relationship you had?
A In Gosport there is something called the Gosport Medical Committee, which is made up of all the practising doctors on the peninsula, which I think at the moment is about 36. We are employed by the health care trust to look after 20 GP beds upstairs from my erstwhile geriatric beds. We have admitting rights to those beds and we are allowed to look after our own patients. We are also invited to look after step-down patients from the acute unit. Although, as a GP you can be much more hard-nosed about refusing to accept somebody who you feel is beyond the capability of the hospital to look after than I could as a clinical assistant downstairs in the wards. That is why you will see something about, "a retrospective audit of your prescribing on the Sultan ward". That is, what I was doing – whether I was prescribing inappropriate opiates upstairs on the GP ward.

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

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

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

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

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

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

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

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

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

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

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

Those are the submissions that I make.

THE CHAIRMAN: I now turn to the legal assessor.

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

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

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

THE CHAIRMAN: Thank you.

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

The parties having been readmitted:

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

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

E:\C\IOC\FOLLOWUP\2002\MARCH\BARTON

In reply please quote NV/HJ/MHu//FPD/2000/2047

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

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

25 March 2002

Detective Sergeant R J Burt
Hampshire Constabulary
Major Incident Complex Police Station
Kingston Complex
Portsmouth
Hampshire PO2 8BU

Dear DS Burt

Dr Jane Ann Barton, BM BCh 1972 Oxfd
Registration No: 1587920

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting 21 March 2002.

Dr Barton attended the meeting, and was legally represented.

After considering submissions from Counsel instructed by the GMC, and also from Dr Barton's legal representatives, the IOC considered that it was **not** necessary for the protection of members of the public and in the public interests or in Dr Barton's own interests to make an order affecting her registration.

Yours sincerely

Code A

Nilla Varsani
Committee Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

E:\C\IOC\FOLLOWUP\2002\MARCH\BARTON

In reply please quote NV/HJ/MHu//FPD/2000/2047

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

25 March 2002

Special Delivery

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dr J A Barton

Code A

Dear Dr Barton

Notification of Decision of the Interim Orders Committee

On 21 March 2002 the Interim Orders Committee of the GMC considered whether it was necessary for the protection of members of the public or was otherwise in the public interest or in your own interests to make an Order under Section 41A(1) of the Medical Act 1983 as amended (the Act).

You were present at the meeting, and were represented by Mr Jenkins, Counsel, instructed by the Medical Defence Union.

At the conclusion of the proceedings of the Interim Orders Committee in your case on 21 March 2002 the Chairman announced the Committee's determination as follows:

> "Dr Barton: The Committee has carefully considered all the evidence before it including the submissions made on your behalf.
>
> The Committee has determined on the basis of the information available to it today that it is not satisfied that it is necessary for the protection of members of the public, in the public interest or in your own interests that an interim order under Section 41A of the Medical Act 1983 as amended should be made in relation to your registration."

Yours sincerely

Code A

Scott Geddes
Assistant Registrar

cc: Mr Barker, The MDU, 230 Blackfriars Road, London SE1 8PT [Ref: ISPB/TOC/0005940/Legal]

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Michael Hudspith

E:\C\IOC\FOLLOWUP\2002\MARCH\BARTON

In reply please quote NV/HJ/MHu//FPD/2000/2047

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

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

25 March 2002

Dr P Old
Acting Chief Executive
Isle of Wight, Portsmouth & SE Hampshire HA
Finchdean House
Milton Road
Portsmouth PO3 6DP

Dear Dr Old

Dr Jane Ann Barton, BM BCh 1972 Oxfd
Registration No: 1587920

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting 21 March 2002.

Dr Barton attended the meeting, and was legally represented.

After considering submissions from Counsel instructed by the GMC, and also from Dr Barton's legal representatives, the IOC considered that it was **not** necessary for the protection of members of the public and in the public interests or in Dr Barton's own interests to make an order affecting her registration.

Yours sincerely

Code A

Nilla Varsani
Committee Section

Code A

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email gmc@gmc-uk.org www.gmc-uk.org

E\Committee\IOC\Followup\2002\March\NHSExec

In reply please quote NV/HJ/IOC/FPD/21Mar02

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

25 March 2002

Mrs Barbara Carter
NHS Executive
Room 2W10
Quarry House
Leeds LS2 7UE

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mrs Carter

I am writing to confirm the decisions taken by the GMC's Interim Orders Committee at its meeting on 21 March 2002. The decisions were as follows:

Name: BARTON, Jane Ann
Registration Number: 1587920
Qualifications: BM BCh 1972 Oxfd
Registered address: **Code A**

Decision: The Committee directed that no order be made.

Name: LATIF, Surraya Wajahat *(formerly Nabi, S Ghulam)*
Registration number:
Qualifications:
Registered address: **Code A**

Decision: The Committee directed that no order be made.

Name: HOLDSWORTH, Darren Scott
Registration number:
Qualifications:
Registered address: **Code A**

Decision: The Committee reviewed the order for interim conditions imposed on 14 December 2001 and directed that for the remainder of the duration of the order Dr Holdsworth's registration should be suspended.
(until 13 June 2003)

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Name: BIHARI, Kailash
Registration Number: Code A
Qualifications:
Registered address:

Decision: The Committee directed that no order should be made.

New orders made by the Committee are subject to review within six months. Orders which have been reviewed will be subject to review within three months.

Yours sincerely

Code A

Nilla Varsani
Committee Secretary

Code A

cc: Angela Hawley, NHS Executive

Dr Barton

IOC 21 March 2002

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

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

Michael Hudspith

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM

Your Ref. : NV/HJ/Mhu/FPD/2000/2047

Tel. : 0845 045 45 45
Direct Dial :
Fax. : 02392 891562

08 April 2002

Ms Varsani
Committee Section
General Medical Council
178 Portland Street
LONDON
W1W 5JE

Dear Ms Varsani

I am writing in response to your letter of the 25th March addressed to Detective Sergeant BURT concerning Dr Jane Anne BARTON, which has been forwarded for my attention.

I have noted the contents of your letter regarding the outcome of the meeting of the 21st March.

For your information I am now the officer with responsibility for any enquiries concerning Dr BARTON and any correspondence should be addressed as shown on this letterhead.

Yours sincerely

Code A

J JAMES
Detective Superintendent

Code A

Tel: Home
Work

Friday 17th May 2002

The Director
Mr Mike Hudspith
The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr Hudspith

RE: GOSPORT WAR MEMORIAL – DEATH OF Mrs E I PAGE

I wish to make a formal complaint against two doctors working at The Gosport War Memorial in Gosport, Hampshire, during the time that my mother was in their care. The doctors concerned are **Dr's A LORD and Jane A BARTON (GP Code No. 3357406)**

My mother was admitted from Queen Alexandra's Hospital, Portsmouth on 27th Feb 1998 and died the evening of the 3rd of March 1998.

The events leading up and including her death were investigated in a serious crimes investigation carried out by The Major Incident Complex, Portsmouth. Her case was serious enough to be sent to medical experts for opinion, I believe this report substantiates concern in her treatment. I also believe you have a copy and am aware of this case.

It is important to note that I was first made aware that there was concern in the treatment of elderly patients during 1998, when Mrs Gillian MacKenzies's case made local press news. At that time I wrote a letter to the police stating that I had concern relating to my mother, this was on the 9th April 2001. I was told that my mother's case would be investigated. I heard nothing until the 13 February 2002. At that time I was invited with other concerned relatives to a meeting with the head of the enquiry team who explained the events of the investigation and the reasons as to why no further action would be taken. At this meeting I first learnt that my mother's case was one of four cases investigated and expert opinions sought. I was also told at this meeting that these reports would be available to me. This promise was rescinded, and I was told later that Court Orders would be required, and this may well be refused.

I subsequently obtained my mothers notes and after perusal with a professional opinion, I found several grave areas of concern. I now understand from Code A (another unhappy relative) that these police reports were sent to you and you have/are investigating further.

I am annoyed that throughout this time I have been kept in the dark by the police as to any investigation made, and the investigating officers decision to take no further action, and his subsequent withdraw of the offer to release the medical opinions. I am presently making a formal complaint to The Chief Constable, Hampshire Police.

I trust you are able to assist me in this very serious matter.

Yours truly,

Code A

Bernard Page

In reply please quote MH/ Misc

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

21 May 2002

Mr Bernard Page

Code A

Dear Mr Page

Re: Gosport War Memorial – Death of Mrs E I Page

Thank you for your letter of 17 May 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Hudspith and he will be in contact as soon as possible.

Yours sincerely

Code A

Desrine Emmanuel
Caseworker Assistant
For Michael Hudspith (Senior Caseworker)
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Code A

Tuesday 21st May 2002

Tel:
Work Code A

The Director
Mr Mike Hudspith
The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr Hudspith

RE: GOSPORT WAR MEMORIAL – DEATH OF Mrs E I PAGE

Thank you for your call on Monday and for the briefing you gave me.

As we discussed I write to formally request all relevant documents you have appertaining to my mother's death.

Yours faithfully

Code A

Bernard Page

Your reference:

Our reference: 2000/2047

21 June 2002

First Class Post

Mr Bernard Page

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Page

Mrs Eva Page

I write further to your letter of 17 May 2002 and our recent telephone conversations regarding your mother's case. Please accept my apologies for the delay in responding.

I have now had an opportunity to speak with Hampshire Constabulary and taken advice from both senior colleagues and our own solicitors about disclosing to you copies of the expert opinions prepared during the recent police investigation.

As with all record holders, the GMC is bound by the terms and conditions of the Data Protection Act 1998 when deciding how and why personal data is processed. Personal data is information about identifiable, living individuals and includes both facts and opinions about the individual. Processing incorporates the concepts of 'obtaining', holding' and 'disclosing' information.

I am advised that, were we to release these documents to you, we may be violating the rights of data subjects (certain individuals named in the documents). I am afraid therefore that due to restrictions placed upon us by the Data Protection Act we are unable, at this time, to disclose the information you have requested.

That said, I am also advised that under the Data Protection Act we can provide personal information to a third party if required to do so by a court order. Should you wish to consider pursuing this option, you should approach a solicitor for advice.

I am sorry that I can not be of further help at this time.

Code A

Code A **Michael Hudspith**
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Code A

28th May 2002

Mr M. Hudspith
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Mr Hudspith,

Mrs Gladys Richards

As progress is being made with your enquires regarding the conduct of medical staff at the Gosport War Memorial Hospital I wish the following concerns to be put on record.

When I approached the Gosport C.I.D. on 2 October 1998 I alleged a case of gross negligence manslaughter relating to the death of my mother, Mrs Gladys Richards. I quoted the points of law to be proved following Lord MacKay's ruling in 1995 concerning the case of Adomako. At that time I had not seen the medical files.

As you are aware the second investigation commencing in October 1999 revealed the contents of the files to me. I subsequently alleged a more serious situation as it appeared to me there was written indication of 'intent'. I am still of that opinion. The total disregard of Dr. Ian Reid's letter dated 5 August 1998 and the discharge letter from Haslar dated 10 August 1998 constitutes more than negligence. In addition the discharge note from Haslar dated 17 August 1998 indicates my mother was once more mobile. The medical files are now in your possession and you are aware of the grave issues raised. The P.C.A. upheld all my complaints relating to 'investigative failures' in the first investigation by Gosport C.I.D. I understand a similar situation has arisen relating to cases brought to the attention of police in 2001 and formal complaints have been lodged with the Chief Constable.

I am aware of the boundaries set for the G.M.C. and cases are not referred to the criminal court. However the patterns set in my mother's case and apparently followed in approximately nine other cases (to date) are such that I feel very strongly they should be dealt with in a Court of Law. A recent remark in a conversation with a police officer "Juries do not like to convict Doctors" says something of the intelligence of the average jury and the explanation of the law by an unbiased judge – let alone the Obiter Dicta by a Judge (Mars – Jones/Carr) (1986)

I hope your legal panel will bear this in mind and make recommendations accordingly before deciding on a hearing only before the G.M.C. I understand that a hearing would be open to the public with press coverage and this could bar a case being heard in the criminal court.

Yours sincerely

Code A

Gillian. M. MacKenzie

Copies:
RT Hon David Blunkett MP
Paul Kernaghan Chief Constable
Nigel Waterson MP Eastbourne
Peter Viggers MP Gosport
Duncan Geer PCA
Paul Close CPS London
David Parry Treasury Counsel

DE- 5/6/02
pages: 2 of 2

In reply please quote Mhu/FPD/2000/2047

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

5 June 2002

Ms Gillian M MacKenzie

Code A

Dear Ms MacKenzie

Re: Mrs Gladys Richards

Thank you for your letter of 28 May 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Hudspith and he will be in contact as soon as possible.

Yours sincerely

Code A

Desrine Emmanuel
Caseworker Assistant
For Michael Hudspith (Senior Caseworker)
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Code A

Code A

28 June 2002

Mr M HUDSPITH
British Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr HUDSPITH,

WAR MEMORIAL HOSPITAL, GOSPORT

It has been brought to my attention that you are involved in an investigation into various members of the medical staff at the above hospital in late 1998, and feel you should be aware of the untimely death of my step-father in September of that year whilst under its care, if you do not know already.

My step-father was Arthur Denis Brian CUNNINGHAM, who was admitted into this hospital on 21 September with serious bed-sores, as outlined in various papers sent by me to the Hampshire Constabulary some considerable time ago. He died on 26 September, apparently from Bronchopneumonia.

For my own peace of mind, I would like you to take account of Mr CUNNINGHAM's case along with the others, and I will be pleased to assist your enquiries in any way possible. To this end, I would be readily available for a personal interview in your office during most of July and August, as I will be residing in London during that period.

I look forward to hearing from you.

Yours faithfully,

Code A

C R S FARTHING

Scanned - 1/7/22
pages: 1 of 1

In reply please quote MH/GWMH/misc

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

1 July 2002

Mr C R S Farthing

Code A

Dear Mr Farthing

War Memorial Hospital, Gosport

Thank you for your letter of 21 February 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Hudspith and he will be in contact as soon as possible.

Yours sincerely

Code A

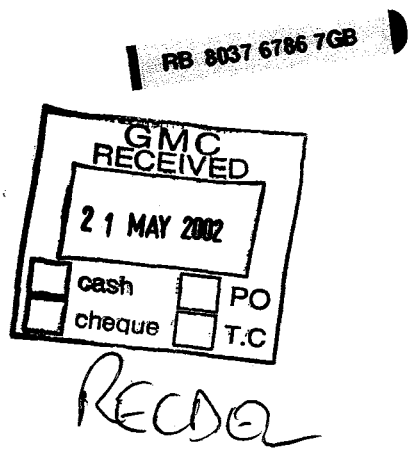
Desrine Emmanuel
Caseworker Assistant
For Michael Hudspith (Senior Caseworker)
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Iain Wilson

Code A



18th May 2002

The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Sir,

Regarding the death of my Father Robert Caldwell Wilson at the Gosport War Memorial Hospital on 18th October 1998.

I wish to make a formal complaint against Dr Jane Barton and Gill Hamblin, who were I believe, responsible for my fathers care, administration of drugs and his death.

My father's death has been investigated by Hampshire police and by two medical experts, the information of their findings is in a secret report now held by Hampshire police.

I wish to be kept fully informed with regards this complaint and the eventual outcome.

If I can be of any further help please do not hesitate to contact me.

Yours sincerely

Code A

Iain Wilson.

Iain Wilson

Code A

30th June 2002

Mr Michael Hudspith
Fitness to Practice directorate
The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Sir,

Please find enclosed a copy of my letter regarding the unlawful killing of my father and my wish to make a formal complaint against the Doctor and Sister responsible for his health and ultimately his death at the Gosport War Memorial Hospital on the 18th October 1998. This letter was dated 18th May 2002 and sent by recorded delivery, to the General Medical Council.

This week I phoned the GMC as I have not received a reply or indeed an acknowledgement to my letter to be told that my complaint had not been received, and that there were in fact, no complaints against Dr Jane Barton.

This I do not believe and in fact, all that has been done is the same as in other relatives complaints regarding deaths at this hospital at the hand of this Doctor, my formal complaint has been deliberately mislaid.

Please confirm receipt of this letter and that my formal complaint has been received and will be acted upon.

I wish to be kept fully informed about this matter and any hearings with regard this Doctor.

I await your early reply

Yours Sincerely

Code A

Iain Wilson

Iain Wilson

Code A

COPY LETTER

18th May 2002

The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Sir,

Regarding the death of my Father Robert Caldwell Wilson at the Gosport War Memorial Hospital on 18th October 1998.

I wish to make a formal complaint against Dr Jane Barton and Gill Hamblin, who were I believe, responsible for my fathers care, administration of drugs and his death.

My father's death has been investigated by Hampshire police and by two medical experts, the information of their findings is in a secret report now held by Hampshire police.

I wish to be kept fully informed with regards this complaint and the eventual outcome.

If I can be of any further help please do not hesitate to contact me.

Yours sincerely

Code A

Iain Wilson.

pages: 2 of 2

In reply please quote MH/GWMH/misc

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

3 July 2002

Mr Iain Wilson

Code A

Dear Mr Wilson

Thank you for your letter and enclosures of 30 June 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Hudspith and he will be in contact as soon as possible.

Yours sincerely

Code A

Desrine Emmanuel
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

In reply please quote 2000/2047

Please address your reply to the Fitness to Practise Directorate
Fax: 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

11 July 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

A member of the Council, who is appointed under Rule 4 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 to give initial consideration to cases, has asked me to notify you, under rule 6(3) of those Rules, that the Council has received from Hampshire Constabulary information which appears to raise a question whether, as a registered medical practitioner, you have committed serious professional misconduct within the meaning of section 36(1) of the Medical Act 1983. A copy of the relevant provisions of the Act is enclosed, together with copies of the Procedure Rules, the GMC's publication "Good Medical Practice" and of a paper about the GMC's fitness to practise processes.

In the information it is alleged that:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs Wilkie's rehabilitation needs;

4. a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Copies of information from Hampshire Constabulary may be found in the enclosed bundle of papers which is indexed at page 2.

The member has directed, in accordance with the Procedure Rules, that the information received from Hampshire Constabulary be referred to the Preliminary Proceedings Committee of the Council. That Committee will consider the information any written explanation provided by you, to determine whether the case should be referred to the Professional Conduct Committee of the Council for inquiry into a charge against you.

You are invited to submit at your earliest convenience a written explanation of the foregoing matter. The next meeting of the Preliminary Proceedings Committee will be held on 29 - 30 August 2002. It is in your interests that the Committee should have time to give careful consideration to any explanation you may wish to offer. You may therefore find it helpful to know that any explanation received by the Council before 21 August 2002 will be circulated to the Committee before the meeting. Any explanation received between 21 and 29 August 2002 will be placed before the Committee on the day of the meeting. Please address your explanation for the attention of Lorna Johnston, Conduct Case Presentation Team, fax number: Code A

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 10 days of receipt of this letter, of the name and address of all of your current employers including the Health Authority with which you have a service agreement, any locum agencies with whom you are registered, and the hospital or 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 or hospital by which you are employed, or have any working arrangements. If you are approved under Section 12 of the Mental Health Act, you must also notify us of this fact.

I enclose a form for you to complete and return in the envelope provided. 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. **Failure to comply with this statutory requirement may result in further proceedings against you.**

The documents enclosed with this letter may contain confidential material. This material is sent to you solely to enable you to respond to the allegations in this letter: it 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 shown above.

Yours sincerely

Code A

Gerry Leighton
Assistant Registrar

Copied to Ian Porter@MDU.
Code A
Code A 11/7/02

Protecting patients, guiding doctors

Michael Hudspith Code A

From: Michael Hudspith Code A
Sent: 11 Jul 2002 12:56
To: FPD Disclosure
Subject: Dr Jane Barton (PPC - 29/08/02)

Importance: High

Dr Barton's case is scheduled to be considered by the PPC at their meeting on **29 - 30 August 2002**

FPD case ref no.: 2000/2047

Dr's reg. no.: 1587920

Nature of Conduct: Substandard clinical practice and care

Notification sent to Dr: 11 July 2002

Charges

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

   ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

   b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

      i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

      ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

      iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

      iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

   ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

   iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

   iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

   b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

      i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

      ii. the prescription for diamorphine, hyoscine and midazolam was undated

      iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

      iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

   c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs

Wilkie's rehabilitation needs;

a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dr Peter Old
Acting Chief Executive
Isle of Wight, Portsmouth and
South East Hampshire Health Authority
Finchdean House
Milton Road
Portsmouth PO3 6DP

Dear Dr Old

Dr Jane Barton (1587920)

I write further to our previous correspondence regarding Dr Barton.

I am now able to confirm that a case against Dr Barton based on the information received Hampshire Constabulary is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Yours sincerely

Code A

Code A **Michael Hudspith**
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dr R I Reid
Department of Elderly Medicine
South Block
Queen Alexandra Hospital
Portsmouth
PO6 3LY

Dear Dr Reid

Dr Jane Barton (1587920)

I write further to our previous correspondence regarding Dr Barton.

I am now able to confirm that a case against Dr Barton based on the information received Hampshire Constabulary is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Yours sincerely

Code A

Code A **Michael Hudspith**
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

Mr Bernard Page

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Page

Gosport War Memorial Hospital

I write further to your letter of 17 May 2002 regarding the death of your mother, Eva Page. I am sorry that I have not been able to update you fully on our consideration of this case before now.

As you are aware, following the conclusion of their investigation, Hampshire Constabulary forwarded their case papers to the GMC for us to consider whether action under our fitness to practise procedures was warranted against any individual doctors.

These papers have been carefully considered and, in relation to Mrs Page's clinical management, it was decided that the reported actions of Dr Lord did not raises any issues serious enough to warrant the restriction or removal of her registration. As such, we do not intend taking any further action against her.

I can confirm, however, that a case against Dr Jane Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that no issue of serious professional misconduct is raised by these allegations, they may conclude the matter by issuing a warning or advisory letter to Dr Barton about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Code A

Yours sincerely

Code A

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

[redacted]

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

Iain Wilson

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Wilson

Dr Jane Barton (1587920)

I write further to your previous letters of 18 May and 30 June 2002. I apologise for the delay in responding and for the apparently false information you were given when you telephoned this office.

I should begin by explaining that that GMC only has jurisdiction over doctors. We are therefore unable to consider a compliant about Sister Hamblin. Should you wish to pursue a complaint about Sister Hamblin you should write to the Nursing and Midwifery Council at 23 Portland Place London W1B 1PZ.

As you are aware, following the conclusion of their investigation, Hampshire Constabulary forwarded their case papers to the GMC for us to consider whether action under our fitness to practise procedures was warranted against any individual doctors.

I am now able to confirm that, in relation to the information relating to Mr Wilson's clinical care, a case against Dr Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Code A

Code A Michael Hudspith
Fitness to Practise Directorate

Code A

Protecting patients,
guiding doctors

Your ref: MIC/Det.Supt/JJ/DM

In reply please quote: 2000/2047

11 July 2002

First Class Post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Det Supt John James
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
Portsmouth PO2 8BU

Dear Det Supt James

Dr Jane Ann Barton (1587920)

I write further to our previous correspondence concerning Dr Barton.

I am now able to confirm that the information forwarded by Hampshire Constabulary concerning Dr Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that no issue of serious professional misconduct is raised by these allegations, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Code A

Code A **Michael Hudspith**
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

Mr C R S Farthing

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Farthing

Gosport War Memorial Hospital

I write further to your letter of 28 June 2002 regarding the death of your step father, Arthur Cunningham.

As you may be aware, following the conclusion of their investigation, Hampshire Constabulary forwarded their case papers to the GMC for us to consider whether action under our fitness to practise procedures was warranted against any individual doctors.

I am now able to confirm that, as a result of information received about Mr Cunningham's clinical management, a case against Dr Jane Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Code A

Code A

Michael Hudspith
Fitness to Practise Directorate

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Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Mrs G MacKenzie

Code A

Dear Mrs MacKenzie

Dr Jane Ann Barton (1587920)

I write further to our previous correspondence and telephone conversations about Dr Barton.

I am now able to confirm that the information forwarded by Hampshire Constabulary concerning Dr Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that no issue of serious professional misconduct is raised by these allegations, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Code A

Code A **Michael Hudspith**
Fitness to Practise Directorate

Code A

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29/05

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

GMC Case Reference Number: 2000/..2047

Name of doctor: Dr J. Barton

Under Section 35A(2)(a)/(b) of the Medical Act 1983 (as amended), you are asked to provide details of your current employment. (Please include employment or arrangements with Health Authorities, locum agencies, hospitals or surgeries and details of bodies outside of the NHS). Failure to comply with the statutory request to provide the above information may result in further proceedings against you:

Name & address of employer	Job title/post
Hampshire and Isle of Wight Practitioner and Patient Service Agency Corkbury House, Fraisgate Winchester Hampshire SO23 8EE	General Practitioner

Cont. over/on separate sheet if neccessary .....

Declaration:

I have provided the GMC with details of my current employment as required by Section 35A(2)(a)/(b) of the Medical Act 1983 (as amended). I confirm that I have given this information truthfully and in good faith.

Name (please print) ..J. A. BARTON.....

Code A

Signature ..... **Date** 10-07-02

1587920

Job title/post

Code A

Dishonesty / criminality

Name & address of employer

GENERAL
MEDICAL
COUNCIL
Protecting patients,
guiding doctors

In reply please quote: SB/FPD/2000/2047

5 August 2002

The Chief Executive
Hampshire & Isle of Wright
Practitioner & Patient Services Agency
Coithking House, Friarsgate
Winchester
Hampsire SO23 8EE

Dear Sir/Madam

I write pursuant to the provisions of Section 35B(1)(b)(I)/(ii) of the Medical Act 1983 (as amended), to inform you that we have received a complaint about Dr J Barton, who has informed us that he works for Hampshire & Isle of Wight Agency as a GP.

The allegations made against Dr Barton are to be considered by the Council's Preliminary Proceedings Committee, who will decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

The allegations to be considered by the Committee are as follows:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

b. Your prescribing to Mrs A of opiate and sedative drugs was inappropriate and/or unprofessional in that

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs A was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs A's condition;

3. a. i. On 6 August 1998 Mrs B was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs B from 20 August 1998 until her death the following day

iv. Mrs B had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs B of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which

were excessive and potentially hazardous to a patient in Mrs B's condition

c. Your management of Mrs B was unprofessional in that you failed to pay sufficient regard to Mrs B's rehabilitation needs;

4. a. i. On 11 August 1998 Mrs C was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs C was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs C did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs C artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs C subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs C received no foods or fluids

b. Your prescribing to Mrs C of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs C was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs C pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs C was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs C's condition

c Your management of Mrs C was unprofessional in that you failed to pay sufficient regard to Mrs Cs' rehabilitation needs.;

5. a. i. On 21 September 1998 Mr D was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr D you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr D did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr D's death on 26 September 1998

b. Your prescribing to Mr D of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr D's condition

c. Your management of Mr D was unprofessional in that you failed to pay sufficient regard to Mr D's rehabilitation needs;

6. a. i. On 14 October 1998 Mr E was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr E's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr E via syringe driver from 16 October 1998

b. Your prescribing to Mr E of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr E's condition

c. Your management of Mr E was unprofessional in that you failed to pay sufficient regard to Mr E's rehabilitation needs.

It is intended that the Preliminary Proceedings Committee will consider these allegations at their meeting on **29 August 2002**.

Should the Committee decide that no issue of serious professional misconduct is raised by these allegations, they may conclude the matter by issuing a warning or advisory letter to the doctor about his future conduct, or decide to take no action. We will write to you again after the Committee meeting to inform you of their decision.

We will inform the Department of Health of these allegations. As deliberations at this stage of our procedures are private, I would ask you not to disclose this information to any persons outside your organisation.

Please write personally to acknowledge receipt of this letter.

Yours sincerely

Code A

Sandra Baldwin
Disclosure Officer

Code A

Protecting patients,
guiding doctors

[redacted]

29-30 Aug

Please quote our reference when communicating with us about this matter

Your ref: ISPB/TOC/9900079/Legal
Your ref: 2000/2047
27th August 2002

THE 1
MDU
MDU Services Limited
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Email: mdu@the-mdu.com
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FAO: Lorna Johnston
General Medical Council
178 Great Portland Street
London, W1

Also by fax: 0207-915-3696

Dear Madam

Re: Dr Jane Barton

I act for Dr Jane Barton, and write with reference to the letter to her from Mr Leighton of 11th July 2002. I would be grateful if this letter could be placed before the Preliminary Proceedings Committee meets to consider this matter on 29th – 30th August, representing Dr Barton's response in relation to the various matters raised in Mr Leighton's letter.

It may be of assistance to the Committee to have some general information at the outset about Dr Barton, the Gosport War Memorial Hospital and in particular about the working environment in which Dr Barton had to practice at the Hospital at the relevant time in 1998. Dr Barton's case was in fact considered by the Interim Orders Committee in March this year. At that time the Committee determined that it was not satisfied it was necessary to make any order affecting Dr Barton's registration. Dr Barton gave evidence on oath before the Committee, which evidence dealt very much with these matters. It may therefore be of considerable assistance for the Committee to have access to Dr Barton's evidence then, and I have pleasure in enclosing a copy of the transcript of the proceedings on the 21st March from pages 5 to 23. The initial pages of the transcript involve representations from Counsel instructed for the GMC, raising issues within the expert reports to which the PPC already has access.

It may nonetheless be helpful for the Committee to have brief further review of Dr Barton's position here. Dr Barton qualified in 1972. She entered General Practice in 1976, joining her present practice in 1980, where she has practised in partnership on a minimum full-time basis. From 1996 to 1998 Dr Barton was a locality Commissioner, seconded to the Health Authority to assist in relation to purchasing issues, and from 1998 to 2000 she was the Chair of the local Primary Care Group.

In addition to her general practice duties, Dr Barton took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial Hospital, a cottage hospital, in 1988. As the Committee will appreciate, the position of Clinical Assistant is a training post, and for Dr Barton it was a part-time appointment. Initially the position was for 4 sessions each week, one of which was allocated to Dr Barton's partners to provide out of hours cover. This was later increased, so that by 1988 the Health Care Trust had allocated Dr Barton 5 clinical assistant sessions, of which 1 ½ were now given

to her partners in her practice for the out of hours aspects of the post. Dr Barton was therefore expected to carry out her day to day responsibilities in this post in effect within 3 ½ sessions each week.

Dr Barton worked on two of the wards at the Hospital, Daedalus, and Dryad Wards. The two wards had a total of 48 beds. About 8 of the beds on Daedalus Ward were for 'slow stream' stroke patients. The remaining beds were otherwise designated to provide continuing care for elderly patients.

Two Consultants in elderly medicine were response for each of the wards. Dr Althea Lord was responsible for Daedalus Ward and Dr Jane Tandy for Dryad Ward. Both Consultants, however, had considerable responsibilities elsewhere and thus their actual time at the Gosport War Memorial Hospital was significantly limited. Dr Lord for example was responsible for an acute ward and a continuing care ward at the Queen Alexandra Hospital in Portsmouth, and had responsibilities at a third site, St Mary's Hospital, also in Portsmouth. As a result, Dr Lord's presence at the hospital was limited to conducting a continuing care ward round on Daedalus Ward every other Monday. She would also be in the hospital, conducting outpatients on Thursday when she would carry out a further ward round in relation to the stroke patients.

Dr Tandy took annual leave towards the end of April 1998 followed immediately thereafter by maternity leave, so that she did not return to work until February 1999. The Trust took the decision that her post should not be filled by a locum. Dr Lord kindly volunteered to make herself available to cover, but the reality was that given her own position as a very busy consultant, she could not carry out a ward round on Dryad Ward. The Committee will appreciate therefore that for much of the relevant period in 1998 with which it is concerned, Dr Barton had no effective consultant support on one of the two wards for which she had responsibilities, with the consultant role on the other ward already being limited.

Dr Barton would arrive at the Hospital each morning when it opened about 7.30am. She would visit both wards, reviewing patients and liasing with staff, before she then commenced her General Practitioner responsibilities at 9am. She would return to the Hospital virtually every lunchtime. New patients, of whom there were about 5 each week, would usually arrive before lunchtime and she would admit patients, write up charts and see relatives. Quite often, in particular if she was the duty doctor, Dr Barton would return to the Hospital after GP surgery hours at about 7pm. She was concerned to make herself available to relatives who were not usually able to see her in the course of their working day. She would attend the Daedalus ward round on Mondays with Dr Lord, but was unable to attend the round for stroke patients on Thursdays.

Further, Dr Barton was concerned to make herself available even outside those hours when she was in attendance at the hospital. The nursing staff would therefore ring her either at her home or at her GP surgery to discuss developments or problems with particular patients. In the event that medicine was to be increased, even within a range of medication already prescribed Dr Barton it would be usual for the nursing staff either to inform Dr Barton of the fact that they considered it necessary to make such a change, or would inform her shortly thereafter of the fact that that increase had been instituted.

When Dr Barton first took up her post as clinical assistant the level of dependency of patients was relatively low. In general the patients did not have major medical needs. However, over time that position changed greatly. Patients who were increasingly dependent would be admitted to the wards, so that in time, and certainly by 1998, many of the patients were profoundly dependent with minimal Bartell scores. There was in consequence a considerable increase in the medical and nursing input required to care for such patients.

Further, at the relevant time the bed occupancy was about 80%. That was then to rise to approximately 90%. There would therefore be as many as 40 or more patients to be seen and/or reviewed by Dr Barton when she attended each day.

As the Committee might anticipate over the 10 years in which she was in post, Dr Barton was able to establish a very good working relationship with the nursing staff at the hospital. She found them to be responsible and caring. They were experienced, as indeed Dr Barton herself became, in caring for elderly dependent patients. Dr Barton felt able to place a significant measure of trust in the nursing staff.

Over the period in which Dr Barton was in post there was no effective increase in the numbers of nursing staff. With the significant number of patients and the considerable increase in dependency over the period, the nurses, like Dr Barton, were faced with an excessive workload.

The picture therefore that emerges by 1998 at this cottage hospital is one in which there had been a marked increase in the dependency of the patients, and indeed an increase in their numbers. There was limited consultant input, reduced still further by the fact that no locum was appointed to cover Dr Tandy's position. By this time the demands on Dr Barton were considerable indeed given that she was expected to deliver this significant volume of care within a mere 3 ½ sessions each week. As the Committee will appreciate from Dr Barton's evidence to the Interim Orders Committee, she raised this matter with management, albeit verbally, saying that she could not manage this level of care for the number of patients, but the reality was that there was no one else to do it. In due course Dr Barton felt unable to continue. She resigned from her post in 2000.

The Committee may feel it is of some significance that her position was then replaced, not with another part-time clinical assistant, but a full-time staff grade. Indeed, Dr Barton's present understanding is that this post may be increased to two full-time positions, and is a clear reflection of the very considerable demands upon her at the relevant time when she was struggling to cope with the care of patients. In addition, the Consultant cover to the two wards was increased to ten sessions per week in 2000. In 1998, Dr Barton had tried to raise the issue and could have walked away, resigning her position at that time. However, she felt obliged to remain, to support her colleagues, and more particularly, to care for her patients. In reality she was trying to do her best in the most trying of circumstances.

For Dr Barton caring for patients on a day by day basis therefore she was left with the choice of attending to her patients and making notes as best she could, or making more detailed notes about those she did see, but potentially neglecting others. In the circumstances, Dr Barton attended to her patients and readily accepts that her note

keeping suffered in consequence. The medical records therefore do not set out each and every review with a full assessment of a condition of a patient at any given point.

Similarly, in relation to prescribing Dr Barton felt obliged to adopt a policy of pro-active prescribing, giving nurses a degree of discretion and administering within a range of medication. As a result, if the patient's condition deteriorated such that they required further medication to ease pain and suffering, that medication could be given even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient. This was of assistance in particular out of hours. It was a practice adopted out of necessity, but one of which Dr Barton had trust and confidence in the nurses who would be acting on her prescripts, and indeed in which the nurses would routinely liase with her as and when increases in medication were made even within the authority of the prescription.

The Committee may feel that it is also of some significance that prescriptions of this nature by Dr Barton were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was Dr Barton ever informed that her practice in this regard was inappropriate.

Lest this observation, and indeed others, in relation to the degree of consultant support appear in any way to be critical of Dr Lord, Dr Barton is anxious to emphasise the evidence which she gave at the Interim Orders Committee in this regard – that Dr Lord was caring, thoughtful and considerate. The reality is that Dr Lord too had a considerable workload, and she did what she could given the constraints upon her.

Professor Ford comments in his report that there may have been inadequate senior medical input into the wards and that it would be important to examine this in detail. It does not appear from this that Professor Ford, or indeed the other experts, were informed by the police of the levels of nursing and medical staffing on the two wards in question. Such information would be of particular importance in evaluating properly any perceived failings on the part of 'junior medical staff' - Dr Barton. Indeed, as the committee will see from the questioning and responses on page 13 of the transcript of the IOC hearing, it may even be the case that Professor Ford was unaware that Dr Barton was the only member of the "non-consultant medical staff" and that she was part time at that.

It was in this context then that Dr Barton came to treat and care for the patients in question, and the committee will no doubt wish to consider that context carefully. With reference to the patients the committee may be further assisted by the following information:

Eva Page

Mrs Page was admitted to the Victory ward of the Queen Alexandra Hospital on 6th February 1998 suffering with anorexia, cachexia, depression and a 2 inch mass in her left hilum which was diagnosed on chest x ray as lung cancer. She had a history of heart failure and was receiving medication accordingly. It was felt that she was too ill to undergo bronchoscopy by way of further examination and on 12th February it was noted that she should receive palliative care and was not for resuscitation.

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On 16th February she was noted to be confused and deteriorating gradually. She was later transferred to Charles ward, a palliative care ward at Queen Alexandra Hospital, and from time to time was noted to be confused, frightened and calling out.

On 25th February Mrs Page was seen by Dr Lord who stopped all medication and commenced Thioridazine, before she was then admitted to the Gosport War Memorial Hospital 2 days later. Dr Barton saw her the same day, clerking her in and assessing her condition. By this stage Mrs Page was totally dependent with a Bartell score of zero. Dr Barton reviewed the notes from the Queen Alexandra Hospital and was aware of the assessments which had been made, including that relating to palliative care.

Dr Barton prescribed Thioridazine and Oramorph on an 'as required' basis. Although she was not in pain at the time, Dr Barton appreciated that given the diagnosis of lung cancer, pain relief with opiates might become necessary. Mrs Page was clearly very ill. In Dr Barton's view she was indeed in terminal decline as others had assessed her to be. Dr Barton recorded in the notes that she was happy for the nurses to confirm death.

It was Dr Barton's practice to record this in a patient's notes if it was felt that the patient was likely to die. This in no way reflected the nature or quality of care to be given to a patient. If a patient died unexpectedly, the nursing staff would be required to call out a duty doctor, there usually being no medical presence at the hospital. If a death was not unexpected - recorded by Dr Barton in this way - Dr Barton was content the nurses should confirm death in the first instance, with Dr Barton or Dr Lord to certify death when next available at the hospital.

In any event, the following day Mrs Page was noted by the nursing staff to be very distressed, calling out for help and saying that she was afraid. Thioridazine was given, but with no effect and it appears to have become necessary to call out the duty doctor.

By 2nd March it seems that Mrs Page was now also in pain. She was assessed by Dr Barton in the morning, who recorded that there had been no improvement on major tranquillisers and she suggested adequate opioids to control Mrs Page's fear and pain. Dr Barton prescribed a Fentanyl patch which would have the effect of a continuous delivery, but which can take some time to be effective. To cover the intervening period, Dr Barton also prescribed 5mgs of Diamorphine intramuscularly, to be given then, with a further 5mgs at 3pm.

From the records it is clear that Dr Lord saw the patient later that day and was aware of the medication which had been given. Dr Lord made two entries in the notes, and in the second she recorded that she had spoken with Mrs Page's son. It is apparent from the note that there had been a further deterioration in Mrs Page's condition and that Dr Lord believed she was dying.

Dr Barton was concerned that Mrs Page might require medication via a syringe driver as a more effective way of alleviating her pain and distress. She prescribed Diamorphine in a 20 - 200mgs/24 hours range as required, together with Hyoscine and Midazolam for subcutaneous delivery. On 3rd March, before the syringe driver was set up by the nursing staff, Mrs Page was noted to have deteriorated still further, and a left sided CVA was

suspected. Midazolam and 20mgs of Diamorphine to be delivered over 24 hours was commenced by syringe driver at 10.50 that morning. That would be the equivalent of the 60mgs of Oramorph she had received in the previous 24 hours. Mrs Page died peacefully at 9.30 that night.

Alice Wilkie

Mrs Wilkie was admitted to the Queen Alexandra Hospital on 31st July 1998 with a history of severe dementia. Her Bartel score was recorded at 1. She was reviewed again on 1st August and the clinician attending her then considered her condition was such that she should not be resuscitated in the event of emergency. She was seen by Dr Lord on 4th August who recorded that her overall prognosis was poor and confirmed that she should not be resuscitated. The plan was for Mrs Wilkie to be admitted to the Gosport War Memorial Hospital for observation.

That transfer took place on 6th August, and Mrs Wilkie was seen initially By Dr Peters, one of Dr Barton's partners, Dr Barton being on sick leave at the time. Dr Lord assessed Mrs Wilkie again on 10th August, recording that her Bartel score was now 2, confirming that she was profoundly dependent.

The nursing records contain no entries for the period 6th August - 17th August, suggesting that this was a time when the staff were profoundly stretched, but on 17th August Mrs Wilkie was noted to have deteriorated over the weekend and that her condition was worsening, from a state which had already been poor.

Dr Barton believes that she saw the patient on 20th August. Although she has not made an entry in Mrs Wilkie's notes, a prescription of subcutaneous Diamorphine - 20 - 200mgsover 24 hours, together with Midazolam and Hyoscine is recorded. 30mgs of Diamorphine over 24 hours with 20mgs of Midazolam was commenced at 1.30 that afternoon, via syringe driver.

Dr Barton saw Mrs Wilkie the following morning, noting the marked deterioration over the past few days and that subcutaneous medication had been commenced. A nursing entry shortly before 1.00 that afternoon recorded that Mrs Wilkie's condition had deteriorated during the morning but she was said to be comfortable and free from pain. Mrs Wilkie died later that day at 6.00pm.

Mrs Gladys Richards

Dr Barton has of course made a lengthy statement concerning the treatment of Mrs Richards, contained in the Committee's papers at pages 153 - 163. The Committee will no doubt consider that statement in detail, being Dr Barton's explanation.

Arthur Cunningham

Mr Cunningham, who suffered from Parkinson's disease and depression, was admitted to the Gosport War Memorial Hospital on 21st September 1998, having been reviewed that day at the Dolphin Day Hospital by Dr Lord. As Dr Lord recorded in her letter to Mr

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Cunningham's GP dictated the same day, Mr Cunningham had a large necrotic sacral ulcer which was extremely offensive. Dr Lord stated that he continued to be very frail.

In her notes in the hospital records, Dr Lord confirmed this, stating that the prognosis was poor and that Mr Cunningham should have 5 - 10mgs of Oramorph if he was in pain. 5mgs of Oramorph was then given at 2.50pm.

Dr Barton saw Mr Cunningham on 21st September, after his admission, and noted that he should have adequate analgesia. She was aware of Dr Lord's view of the poor prognosis and, agreeing with that assessment, Dr Barton recorded that she was happy for the nursing staff to record death.

The notes contain photographs of the sacral sore at the time of Mr Cunningham's admission, which are far from clear in the photocopies of the medical records now available. Dr Barton recalls, however, that it was about the size of a fist. Concerned that Mr Cunningham might require further pain relief in due course, through increasing pain and tolerance, Dr Barton prescribed Diamorphine - 20 - 200mgs, Midazolam 20 - 80mgs and Hyoscine over 24 hours subcutaneously, to ensure a continuous delivery of pain relief and that there would be no breakthrough pain.

A further dose of Oramorph was given at 8.15pm, but the nursing records show that Mr Cunningham appears to have remained in pain and required assistance to settle for the night. The syringe driver was commenced at 11.10 that night, delivering 20mgs of Diamorphine and 20mgs of Midazolam, following which Mr Cunningham slept soundly. He was noted to be much calmer the following morning.

Dr Barton would have seen Mr Cunningham each day. On 23rd September the nursing notes record that Mr Cunningham had become chesty and Hyoscine was added to dry the secretions on his chest. The records make clear the view that by this stage Mr Cunningham was dying. At 8pm on 23rd September the Midazolam was increased to 60mgs to maintain Mr Cunningham's comfort.

On 24th September Dr Barton noted that Mr Cunningham's pain was being controlled by the analgesia - just. The nursing records show that the night staff had reported Mr Cunningham was in pain when being attended to, and the day staff also noted pain. The Diamorphine was increased to 40mgs and the Midazolam to 80mgs accordingly. Mr Cunningham was then noted by the nurses to have a peaceful night.

The following day Mr Cunningham was seen by Dr Brooks, one of Dr Barton's partners, who confirmed that Mr Cunningham remained very poorly. Dr Barton also saw Mr Cunningham that day, writing up a prescription for Diamorphine for 40 - 200mgs, Midazolam at 20 - 200mgs, together with Hyoscine. In fact it was necessary to administer 60mgsof Diamorphine and 80mgs ofMidazolam/24 hours via the syringe driver in order to control the pain.

The following day, 26th September, Mr Cunningham's condition continued to deteriorate slowly. Diamorphine was increased to 80mgsover 24 hours, and the Midazolam to 100mgs to control the pain. Mr Cunningham then died peacefully at 11.15 that evening.

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27th August 2002

Robert Wilson

Mr Wilson was admitted to the Queen Alexandra Hospital on 21st September 1998 with a fracture of the humerus. He had a history of Code A heart failure, for which he was receiving medication. X ray revealed displacement, but Mr Wilson was unwilling to undergo surgery. He was in pain, receiving a range of painkillers, including opiates in the form of Morphine and Diamorphine.

On 29th September it was noted that resuscitation was considered inappropriate in view of the poor quality of life and the poor prognosis. On 8th October he was assessed by a psychogeriatrician who said that he was in low mood, presenting with a wish to die and disturbed sleep, possibly secondary to pain. She diagnosed early dementia, possibly alcohol related, and depression.

A decision was then made to transfer Mr Wilson to the Gosport War Memorial Hospital and Dr Barton clerked him in following his arrival on 14th October. Dr Barton noted the plan as gentle mobilisation. She believes Mr Wilson was in a degree of pain following his transfer, and she prescribed Oramorph in addition to Paracetamol on an 'as required' basis. Oramorph was given for pain relief at 2.45pm and 11.45pm on 14th October.

Dr Barton wrote a further prescription for Oramorph on 15th October, for 10mgs 4 hourly and 20mgs at night to control the pain in Mr Wilson's arm, which persisted. As a result of that Oramorph, Mr Wilson was noted to have settled and slept well.

Later that night Mr Wilson appears to have suffered what was thought to have been a silent myocardial infarction. Dr Knapman was called to see him on 16th October, and he increased the dose of Frusemide Mr Wilson was already receiving for his pre-existing heart failure. Dr Knapman noted a decline overnight with a shortness of breath, bubbling, and a week pulse. He had significant oedema in the arms and legs, and was unresponsive to the spoken word.

Dr Barton believes she may have come in to see Mr Wilson later in the day. The nursing record for 15th October had noted that Mr Wilson had difficulty in swallowing, and as he would have had difficulty in taking Oramorph, Dr Barton decided in view of his condition now that he should receive pain relief subcutaneously, converting to Diamorphine via syringe driver. She prescribed 20 - 200mgs of Diamorphine, 20 - 80mgs of Midazolam, together with Hyoscine for the chest secretions. The Diamorphine was then commenced at 20mgs over 24 hours, entirely consistent with the 60mgsofOramorph which had been required for pain relief the previous day. As a result, the nursing records show that after the Diamorphine was commenced, Mr Wilson had not been distressed and appeared comfortable.

On 17th October Dr Peters was called to see Mr Wilson. Dr Peters noted that he was comfortable, though he had deteriorated. Dr Peters also recorded that the nursing staff should verify death if necessary. Later that day the Diamorphine was increased to 40mgs over 24 hours and Midazolam added at 20mgs/24 hours. Mr Wilson was producing significant secretions, requiring suctioning, apparently being in heart failure, and the Hyoscine was also increased. In consequence, the secretions were noted not to disturb him, and he appeared to be comfortable.

Our ref: ISPB/TOC/9900079/Legal
Your ref: 2000/2047
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The following day he was seen again by Dr Peters. The nurses noted that there had been a further deterioration in his already poor condition. The syringe driver was reviewed at 2.50 that afternoon, and the Diamorphine increased to 60mgs and the Midazolam to 40mgs. Mr Wilson continued to require regular suctioning and Dr Peters prescribed a further increase in the Hyoscine.

Mr Wilson continued to deteriorate in the course of the afternoon, and he died peacefully that night at 11.40pm.

Summary

Dr Barton endeavoured to care for her patients in what were clearly very difficult circumstances. She did not wish to abandon her consultant, her nursing colleagues and the patients. She raised her concerns with management, but to no avail. The information above about the individual patients will hopefully assist the Committee in considering this matter, coupled most importantly with an understanding of the situation in which Dr Barton found herself. I respectfully suggest that the Committee can reasonably conclude that this is not essentially a matter of professional conduct, but rather an issue of lack of resources and proper management.

Yours faithfully

Code A

Ian S P Barker Code A
Solici

Code A

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.

A 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.

B 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 C 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?
D 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.
E 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 F 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?
G 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.

H Q Did that position change as time went on?
A That position changed.

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

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

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

Q What you have told us is that, over time, the level of dependence of the patients increased.
A It escalated enormously: to the point where I began to be saying to my employers, "I can't manage this level of care for this number of patients on the commitment I have". But there was not anybody else to do it. During 1998, when the consultant on Dryad went on 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.

A 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.

B

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
C 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.

D 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
E 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
F 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.

G 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*
H *Palliative Care Guide* and we all carry the *Wessex Palliative Care Handbook* around with us, which contains a sort of----

Q Is that it?
A Which you carry in your coat pocket. [*indicates document*]

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

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

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

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

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

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

A 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 B 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 C 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 D 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 – E 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 F 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 G 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?
H 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

A 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?

B

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
C 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
D 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
E 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
F 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----
G 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.

H Q Did you feel that your relationship with the nursing staff was such that such informal communication could take place?
T A Reed & Co A I trusted them implicitly. I had to.

A 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
B 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
C 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".

D 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
E 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
F 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.

G 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.

H Q ...in the cottage hospital.
A No.

A 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.

B 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",

C – 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?
D 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
E 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?
F A Yes.

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

G 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
H significantly higher volume of patients to your cottage hospital and with much higher levels of dependency?

A 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
B 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
C 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.

D 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".

E 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
F 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.

G

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
H us", he says,

A

"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,

B

"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".

C

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:

D

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,

E

"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.

F

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.

G

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.

H

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

A 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".

B The next document in time is a letter from Dr Jarrett dated 7 March, by way of response. I do not need to read it to you, but you have heard Dr Barton suggest that there was a request, effectively, for three quarters of a million pounds from the primary care group to go towards the local hospital. You may find a hint of that in the last paragraph of this letter.

C 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
D 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
E 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".

F 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
G 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.

H

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

A 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.

B 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
C 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.

D 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.

E 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.

F 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.

G 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.

H 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.

A 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, B 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. C You will know the results of the police investigation: that a decision has been taken not to charge.

I repeat what I have said. It is slightly troubling that it is not apparent that the experts instructed by the police have been presented with the full picture of Dr Barton's clinical involvement with these patients before being invited to express a view. But I say that it is not in the public interest either for this body to impose D 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 E 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.

F 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 G 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.

H

THE CHAIRMAN: Thank you.

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

The parties having been readmitted:

B 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
C today, that it is not satisfied that it is necessary for the protection of members of the public, in the public interest or in your own interests that an interim order under Section 41A of the Medical Act 1983 as amended should be made in relation to your registration.

D

E

F

G

H

29+30 Aug.

Mr G Leighton Assistant Registrar
Fitness to Practise Directorate
General Medical Council
178,Great Portland St
London W1W 5JE

Dr J Barton

Code A

Reference 2000/2047

18th July 2002

Dear Mr Leighton

This is to acknowledge receipt of y r letter of 11th July 2002.

Yours Sincerely

Code A

Dr Jane Barton

Dr Jane Barton (2000/2047)
(Interested Parties)

Dr Jane Barton Code A
Code A

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Mr Bernard Page (son of Eva Page)
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Mr Iain Wilson (son of Robert Wilson)
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Mrs Gillian MacKenzie (daughter of Gladys Richards)
Code A

Mr C R S Farthing (step son of Arthur Cunningham)
Code A

Mrs M Jackson (daughter of Alice Wilkie)
Code A

[redacted]

e LPP

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Code A

CONFIDENTIAL
Sandra Baldwin
Disclosure Officer
General Medical Council
178 Great Portland Street
London
W1W 5JE

15 August 2002
Your ref SB/FPD/2000/2047

Dear Ms Baldwin

I refer to your letter dated 5 August 2002 received today regarding Dr J Barton.

As this Agency works on behalf of PCTs across Hampshire and the Isle of Wight, I have forwarded a copy of your letter to Mr Ian Piper, Chief Executive, Fareham and Gosport PCT as it is the PCT responsible for the provision of primary care in the area that Dr Barton practices.

Code A

General Manager

Cc: Ian Piper, Chief Executive, Fareham and Gosport PCT

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
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29th July 2002

Mr M Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Mr Hudspith

Re: Dr Jane Ann BARTON (1587920)

Thank you for your letter of the 11th July concerning the above named which I have seen on my return from holiday.

I note the private nature of the current proceedings and await an update in due course. Would you please note that I have moved to a new position and can be contacted in future at the address on this letterhead.

Yours sincerely

Code A

J JAMES
Chief Superintendent

Isle of Wight, Portsmouth and South East Hampshire
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Code A

Our Ref: PO/JD/031502jb.doc

15 March 2002

Private & Confidential
Dr Jane Barton

Code A

I wrote to you on 13 February 2002 setting out our agreement on restrictions to your medical practice. At that time it was not possible to put a timescale on these restrictions, but we agreed to review the situation monthly.

I understand that you are due to appear before the GMC in the very near future. Therefore I propose that we continue with the current restrictions until we have the result of the GMC's deliberations.

Thank you for your continued co-operation.

Yours sincerely

Code A

Dr Peter Old
Acting Chief Executive
Code A

cc: Michael Hudspith, GMC

Portsmouth HealthCare NHS
NHS Trust

Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
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PO6 3LY

Tel 023 9228 6000
Fax 023 9220 0381

Detective Superintendent John James
Major Incident Room
Hampshire Constabulary
Kingston Crescent
Portsmouth

08 March 2002

RIR/cmp

Dear Superintendent James

Further to you letter of 5th February 2002, to Mr Millett regarding Police enquiries at Gosport War Memorial Hospital and our subsequent discussion, we are considering within the Trust what further appropriate action we need to take as the employer of the staff named in the three reports commissioned by the Police.

In the course of this we have identified several inaccuracies in the text of one of the reports (that from Professor Ford). I am quite sure that these are to do with a misreading of the draft when finally being typed up, but given that the GMC and UKCC, along with ourselves, are considering individual staff on the basis of these reports, I felt that I should write highlighting the points so that they can be corrected:

- **Page 17, paragraph 3.13, fourth sentence**

  This reads "poor assessment by Dr. Lord"

  However in view of the subsequent sentence (which reads that "the assessment by Dr Lord was thorough and competent") and of the context of the patient's medical notes (where there is a comprehensive note by Dr Lord but only four lines by Dr Barton), we assume that this should read "poor assessment by Dr Barton".

- **Page 21, paragraph 4.1, line seven**

  This reads "... she is not refusing fluids ..."

  The G.P. letter referred to states "... she is now refusing fluids".

- **Page 26, paragraph 5.5**

This lists the dates of prescriptions as in September, whereas the prescription chart for the patient shows them as in October.

❖ **Page 27, paragraph 5.9, line one**

This reads as ".. deteriorated on 15 September..."

This should read "October". The patient was admitted on 22 September and was not an in-patient on 15 September.

In paragraph 5.9 there is a reference to Mr Wilson having been seen by the "on-call Doctor". The on-call Doctor concerned was Dr A C Knapnan.

❖ **Page 34, paragraph 6.16, final sentence**

This reads "... was likely to have resulted could have resulted..."

We assume that only one of these statements is meant to be there.

Yours sincerely

Code A

Dr R I Reid
Medical Director

cc: GMC
UKCC
CHI

Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

JULY 2002

CHI
COMMISSION FOR HEALTH IMPROVEMENT

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Contents

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CHI wishes to thank the following people for their help and cooperation with the production of this report:

- the patients and relatives who contributed either in person, over the phone or in writing. CHI recognises how difficult some of these contacts were for the relatives of those who have died
- staff interviewed by CHI's investigation team (see appendix C) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millett, Chief Executive (until 31 March 2002) and Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust (since 1 April 2002)
- staff and patients who welcomed the CHI team on to the wards during observation work
- Detective Superintendent John James, Hampshire Constabulary
- the agencies listed in appendix D who gave their views and submitted relevant documents to the investigation

Executive summary

CHI has undertaken this investigation as a result of concerns expressed by the police and others around the care and treatment of frail older people provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001. CHI is grateful to the Hampshire Constabulary for sharing information with us which contributed towards the local and national recommendations CHI makes to improve the care of this vulnerable group of NHS patients.

CHI has conducted a detailed review of the systems in place to ensure good quality patient care. CHI does not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual.

Key conclusions

CHI concludes that a number of factors, detailed in the report, contributed to a failure of trust systems to ensure good quality patient care:

- there were insufficient local prescribing guidelines in place governing the prescription of powerful pain relieving and sedative medicines
- the lack of a rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for older people not being questioned
- the absence of adequate trust wide supervision and appraisal systems meant that poor prescribing practice was not identified
- there was a lack of thorough multidisciplinary total patient assessment to determine care needs on admission

CHI also concludes that the trust now has adequate policies and guidelines in place which are being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Key findings

National and local context (Chapter 3)

- Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team.
- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.

Arrangements for the prescription, administration, review and recording of medicines (Chapter 4)

- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the "Wessex guidelines", this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.
- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

Quality of care and the patient experience (Chapter 5)

- Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.
- Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

Staffing arrangements and responsibility for patient care (Chapter 6)

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff.

Lessons learnt from complaints (Chapter 7)

- The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

Clinical governance (Chapter 8)

- The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

Recommendations

It is clear from a number of CHI recommendations to the Fareham and Gosport Primary Care Trust (PCT) and the East Hampshire PCT, that continued close and effective working relationships between both PCTs will be essential in order to implement the recommendations in this report. CHI is aware of the high level of interdependence that already exists between these two organisations and urges that this continues.
CHI is aware that many of these recommendations will be relevant to emerging PCTs and urges all PCTs to take action where appropriate.

Fareham and Gosport/ East Hampshire Primary Care Trust

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

3. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

4. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

5. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

6. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

7. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

8. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

9. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

10. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

11. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

12. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

13. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

14. The Fareham and Gosport PCT and the East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

15. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

16. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangements, clinical governance responsibilities and training needs.

17. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

18. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

19. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

20. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

21. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

22. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

Hampshire and Isle of Wight Strategic Health Authority

23. Hampshire and Isle of Wight Strategic Health Authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

Department of Health

24. The Department of Health should assist in the promotion of an NHS wide understanding of the various terms used to describe levels of care for older people.

25. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

1 | Terms of reference and process of investigation

1.1 During the summer of 2001, concerns were raised with CHI about the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the Gosport War Memorial Hospital. These concerns were also about the responsibility for clinical care and transfer arrangements with other hospitals.

1.2 On 22 October 2001, CHI launched an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust was responsible at the Gosport War Memorial Hospital. CHI's decision was based on evidence of high risk activity and the likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

1.3 The investigation terms of reference were informed by a chronology of events provided by the trust surrounding the death of one patient. Discussions were also held with the trust, the Isle of Wight, Portsmouth and South East Hampshire Health Authority and the NHS south east regional office to ensure maximum learning locally and for the NHS.

1.4 The terms of reference agreed on 9 October 2001 are as follows:

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

i) staffing and accountability arrangements, including out of hours

ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management

iii) arrangements for the prescription, administration, review and recording of drugs

iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations

v) arrangements to support patients and their relatives and carers towards the end of the patient's life

vi) supervision and training arrangements in place to enable staff to provide effective care

In addition, CHI will examine how lessons to improve patient care have been learnt across the trust from patient complaints.

The investigation will also look at the adequacy of the trust's clinical governance arrangements to support inpatient continuing and rehabilitation care for older people.

CHI's investigation team

1.5 CHI's investigation team were:

- Alan Carpenter, Chief Executive, Somerset Coast Primary Care Trust
- Anne Grosskurth, CHI Support Investigations Manger
- Dr Tony Luxton, Consultant Geriatrician, Cambridge City Primary Care Trust
- Julie Miller, CHI Lead Investigations Manager
- Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
- Mary Parkinson, lay member (Age Concern)
- Jennifer Wenborn, Independent Occupational Therapist

1.6 The team was supported by:

- Liz Fradd, CHI Director of Nursing, lead CHI director for the investigation
- Nan Newberry, CHI Senior Analyst
- Ian Horrigan, CHI Analyst
- Kellie Rehill, CHI Investigations Coordinator
- a medical notes review group established by CHI to review anonymised medical notes (see appendix E)
- Dr Barry Tennison, CHI Public Health Adviser

The investigation process

1.7 The investigation consisted of five interrelated parts:

- review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (see appendix A for a list of documents reviewed)
- analysis of views received from 36 patients, relatives and friends about care received at Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls and a short questionnaire (see appendix B for an analysis of views received)

- a five day visit by CHI's investigation team to Gosport War Memorial Hospital when a total of 59 staff from all groups involved in the care and treatment of older people at the hospital and trust managers were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards (see appendix C for a list of all staff interviewed)
- interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (see appendix D for a list of organisations interviewed)
- an independent review of anonymised clinical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendices E and F. CHI shared the summary with the Fareham & Gosport PCT in May 2002

2 | Background to the investigation

Events surrounding the CHI investigation

Police investigations

2.1 A relative of a 91 year old patient who died in August 1998 on Daedalus ward made a complaint to the trust about her care and treatment. The police were contacted in September 1998 with allegations that this patient had been unlawfully killed. A range of issues were identified by the police in support of the allegation and expert advice sought. Following an investigation, documents were referred to the Crown Prosecution Service in November 1998 and again in February 1999. The Crown Prosecution Service responded formally in March 1999 indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.

2.2 Following further police investigation, in August 2001, the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

2.3 Local media coverage in March 2001 resulted in 11 other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate. Two expert reports were received in December 2001 which were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.

2.4 In February 2002, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the General Medical Council, the United Kingdom Central Council (after 1 April 2002, the Nursing and Midwifery Council), the trust, the Isle of Wight, Portsmouth and East Hampshire Health Authority and the NHS south east regional office.

2.5 The police made the trust aware of potential issues around diamorphine usage in December 1998, and were sent the expert witness reports in February 2002.

Action taken by professional regulatory bodies

2.6 The General Medical Council is currently reviewing whether any action against any individual doctor is warranted under its fitness to practice procedures.

2.7 The Nursing and Midwifery Council are considering whether there are any issues of professional misconduct in relation to any of the nurses referred to in police documentation.

Complaints to the trust

2.8 There have been 10 complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and December 1998 raised concerns which included pain management, the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which triggered the initial police investigation. This complaint was not pursued through the NHS complaints procedure.

Action taken by the health authority

2.9 In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people in 1998 and, secondly, as the body through which GPs were permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered by GPs on hospital premises.

2.10 In June 2001, the health authority voluntary local procedure for the identification and support of primary care medical practitioners whose practice is giving cause for concern reviewed the prescribing practice of one local GP. No concerns were found. This was communicated to the trust.

2.11 In July 2001, the chief executive of the health authority asked CHI for advice in obtaining a source of expertise in order to reestablish public confidence in the services for older people in Gosport. This was at the same time as the police contacted CHI.

2.12 Following receipt of the police expert witness reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers and sedatives (opiates and benzodiazepines) in general practice.

Action taken by the NHS south east regional office

2.13 For the period of the investigation, the NHS regional offices were responsible for the strategic and performance management of the NHS, including trusts and health authorities. The NHS south east regional office had information available expressing concerns around prescribing levels at the Gosport War Memorial Hospital. Information included a report by the Health Service Ombudsman and serious untoward incident reports forwarded by the trust in April and July 2001 in response to media articles about the death of a patient at the Gosport War Memorial Hospital.
The health authority and NHS south east regional office met to discuss these issues on 6 April 2001.

3 | National and local context

National context

3.1 The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS Plan and the Standing Nursing and Midwifery Committee's 2001 annual report found aspects of care to be deficient. National concerns raised include: an inadequate and demoralised workforce, poor care environments, lack of seamless care within the NHS and ageism. The NHS Plan's section *Dignity, security and independence in old age*, published in July 2000, outlined the government's plans for the care of older people, detailed in the national service framework.

3.2 The national service framework for older people was published in March 2001 and sets standards of care for older people in all care settings. It aims to ensure high quality of care and treatment, regardless of age. Older people are to be treated as individuals with dignity and respect. The framework places special emphasis on the involvement of older patients and their relatives in the care process, including care planning.

3.3 National standards called *Essence of Care*, published by the Department of Health in 2001, provide standards for assessing nursing practice against fundamental aspects of care such as nutrition, preventing pressure sores and privacy and dignity. These are designed to act as an audit tool to ensure good practice and have been widely disseminated across the NHS.

Trust background

3.4 Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust between April 1994 and April 2002. The hospital is situated on the Gosport peninsula and has 113 beds. Together with outpatient services and a day hospital, there are beds for older people and maternity services. The hospital does not admit patients who are acutely ill and it has neither an A&E nor intensive care facilities. Portsmouth Healthcare NHS Trust provided a range of community and hospital based services for the people of Portsmouth, Fareham, Gosport and surrounding areas. These services included mental health (adult and elderly), community paediatrics, elderly medicine, learning disabilities and psychology.

3.5 The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/2002 the trust had a budget in excess of £100 million and over 20% of income spent on its largest service, elderly medicine. All the trust's financial targets were met in 2000/2001.

Move towards the primary care trust

3.6 Portsmouth Healthcare NHS Trust was dissolved on 31 March 2002. Services have been transferred to local primary care trusts (PCTs), including Fareham and Gosport PCT, which became operational as a level four PCT in April 2002. Arrangements have been made for each PCT to host provider services on a district wide basis but each PCT retains responsibility for commissioning its share of district wide services from the host PCT. Fareham and Gosport PCT will manage many of the staff, premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Medical staff involved in the care of older people, including those working at the Gosport War Memorial Hospital, are now employed by the East Hampshire PCT.

Portsmouth Healthcare NHS Trust strategic management

3.7 The trust board consisted of a chair, five non executive directors, the chief executive, the executive directors of operations, medicine, nursing and finance and the personnel director. The trust was organised into six divisions, two of which are relevant to this investigation. The Fareham and Gosport division, which managed the Gosport War Memorial Hospital, and the department of medicine for elderly people.

3.8 CHI heard that the trust was well regarded in the local health community and had developed constructive links with the health authority and local primary care groups (PCGs). For example, in the lead up to the formation of the new PCT, Portsmouth Healthcare NHS Trust's director of operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the trust on the development of intermediate care and clinical governance. High regard and respect for trust staff was also commented on by the local medical committee, Unison and the Royal College of Nursing.

Local services for older people

3.9 Before April 2002, access to medical beds for older people in Portsmouth (which included acute care, rehabilitation and continuing care) was managed through the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. Some of the beds were located in community hospitals such as the Gosport War Memorial Hospital, where the day to day general management of the hospital was the responsibility of the locality divisions of Portsmouth Healthcare NHS Trust. The Fareham and Gosport division of the trust fulfilled this role at the Gosport War Memorial Hospital.

3.10 The department of medicine for elderly people has now transferred to East Hampshire PCT. The nursing staff of the wards caring for older people at the Gosport War Memorial Hospital are now employed by the Fareham and Gosport PCT. Management of all services for older people has now transferred to the East Hampshire PCT.

3.11 General acute services were, and remain, based at Queen Alexandra and St Mary's hospitals, part of the Portsmouth Hospitals NHS Trust, the local acute trust. Though an unusual arrangement, a precedent for this model of care existed, for example in Southampton Community NHS Trust.

3.12 Until August 2001, the Royal Hospital Haslar, a Ministry of Defence military hospital on the Gosport peninsula, also provided acute medical care to civilians, many of whom were older people, as well as military staff.

Service performance management

3.13 Divisional management at Portsmouth Healthcare NHS Trust was well defined, with clear systems for reporting and monitoring. The quarterly divisional review was the principal tool for the performance management of the Fareham and Gosport division. The review considered regular reports on clinical governance, complaints and risk. Fareham and Gosport division was led by a general manager, who reported to the operational director. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level.

Inpatient services for older people at the Gosport War Memorial Hospital 1998-2002

3.14 Gosport War Memorial Hospital provides continuing care, rehabilitation, day hospital and outpatient services for older people and was managed by the Fareham and Gosport division. In November 2000, as a result of local developments to develop intermediate and rehabilitation services in the community, there was a change in the use of beds at the hospital to provide additional rehabilitation beds.

3.15 In 1998, three wards at Gosport War Memorial Hospital admitted older patients for general medical care: Dryad, Daedalus and Sultan. This is still the case in 2002.

Figure 3.1 Inpatient provision at Gosport War Memorial Hospital by ward

Ward	1998	2002
Dryad	20 continuing care beds. Patients admitted under the care of a consultant, with some day to day care provided by a clinical assistant.	20 continuing care beds for frail elderly patients and slow stream rehabilitation. Patients admitted under the care of a consultant. Day to day care is provided by a staff grade doctor.
Daedalus	16 continuing care beds and 8 for slow stream rehabilitation. Patients admitted under the care of a consultant, some day to day care provided by a clinical assistant.	24 rehabilitation beds: 8 general, 8 fast and 8 slow stream (since November 2000). Patients admitted under the care of a consultant. Day to day care provided by a staff grade doctor.
Sultan	24 GP beds with care managed by patients' own GPs. Patients were not exclusively older patients; care could include rehabilitation and respite care. A ward manager (or sister) managed the ward, which was staffed by Portsmouth Healthcare NHS Trust staff.	The situation is the same as in 1998, except that the nursing staff are now employed by Fareham and Gosport PCT.

Admission criteria

3.13 The current criteria for admission to both Dryad and Daedalus wards are that the patient must be over 65 and be registered with a GP within the Gosport PCG (now a part of Fareham and Gosport PCT). In addition, Dryad patients must have a Barthel score of under 4/20 and require specialist medical and nursing intervention. The Barthel score is a validated tool used to measure physical disability. Daedalus patients must need multidisciplinary rehabilitation, for example following a stroke.

3.14 There was, and still is, a comprehensive list of admission criteria for Sultan ward developed in 1999, all of which must be met prior to admission. The criteria state that patients must not be medically unstable and no intravenous lines must be in situ.

Elderly mental health

3.15 Although not part of the CHI investigation, older patients are also cared for on Mulberry ward, a 40 bed assessment unit comprising Collingwood and Ark Royal wards. Patients admitted to this ward are under the care of a consultant in elderly mental health.

Terminology

3.16 CHI found considerable confusion about the terminology describing the various levels of care for older people in written information and in interviews with staff. For example, the terms stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care were all used. CHI was not aware of any common local definition for these terms in use at the trust or of any national definitions. CHI stakeholder work confirmed that this confusion extended to patients and relatives in terms of their expectations of the type of care received.

KEY FINDINGS

1. Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team. The chief executive was accessible to and well regarded by staff both within the trust and in the local health economy. Good links had been developed with local PCGs.

2. The case note review undertaken by CHI confirmed that the admission criteria for both Dryad and Daedalus wards were being adhered to over recent months and that patients were being appropriately admitted. However, CHI found examples of some recent patients who had been admitted to Sultan ward with more complex needs than stipulated in the admission criteria that may have compromised patient care.

3. There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation that had not been fulfilled.

RECOMMENDATIONS

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Hampshire and Isle of Wight strategic health authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

3. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

4. The Department of Health should assist in the promotion of an NHS wide shared understanding of the various terms used to describe levels of care for older people.

4 | Arrangements for the prescription, administration, review and recording of medicines

Police inquiry and expert witness reports

4.1 CHI's terms of reference for its investigation in part reflected those of the earlier preliminary inquiry by the police, whose reports were made available to CHI.

4.2 Police expert witnesses reviewed the care of five patients who died in 1998 and made general comments in the reports about the systems in place at the trust to ensure effective clinical leadership and patient management on the wards. The experts' examination of the use of medicines in Daedalus, Dryad and Sultan wards led to significant concern about three medicines, the amounts which had been prescribed, the combinations in which they were used and the method of their delivery. In summary:

- there was no evidence of trust policy to ensure the appropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain. It was the view of the police expert witnesses that a more reasonable response would have been the prescription of mild to moderate medicine initially with appropriate review in the event of further pain followed up
- there was inappropriate combined subcutaneous administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death
- there were no clear guidelines available to staff to prevent assumptions being made by clinical staff that patients had been admitted for palliative, rather than rehabilitative care
- there was a failure to recognise potential adverse effects of prescribed medicines by clinical staff
- clinical managers failed to routinely monitor and supervise care on the ward

It is important to emphasise that these reports were not produced for this CHI investigation and CHI cannot take any responsibility for their accuracy. Whilst the reports provided CHI with very useful information, CHI has relied on its own independent scrutiny of data and information gathered during the investigation to reach the conclusions in this chapter.

Medicine usage

4.3 In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines issued from the pharmacy and does not include any wastage, nor can it verify the quantity of medicines administered to each patient. As the data does not offer any breakdown of casemix, it is not possible to determine how complex the needs of patients were in each year. Staff speaking to CHI described an increase in the numbers of sicker patients in recent years. A detailed breakdown of medicines issued to each ward is attached at appendix I.

4.4 The experts commissioned by the police had serious concerns about the level of use of these three medicines (diamorphine, haloperidol and midazolam) and the apparent practice of anticipatory prescribing. CHI shares this view and believes the use and combination of medicines used in 1998 was excessive and outside normal practice. The following figures indicate the use of each medicine by ward and year, plotted alongside the number patients treated (finished consultant episodes).

4.5 The trust's own data, provided to CHI during the site visit week, illustrates a marked decline in the usage of diamorphine, haloperidol and midazolam in recent years. This decline has been most pronounced on Dryad ward and is against a rise in FCEs during the same timeframe. The trust's data demonstrates that usage of each of these medicines peaked in 1998/99. On Sultan ward, the use of haloperidol and midazolam have also declined in recent years with a steady increase in FCEs. Diamorphine use, after declining dramatically in 1999/00, showed an increase in 2000/01.

Medicine issued 1997/1998-2000/2001 according to the number of finished consultant episodes per ward, based on information provided by the Portsmouth Healthcare NHS Trust (see appendices H and I)

Figure 4.1 Diamorphine use – Daedalus ward

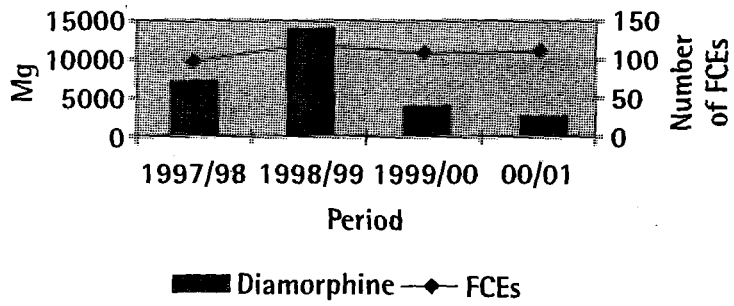


Figure 4.2 Haloperidol use – Daedalus ward

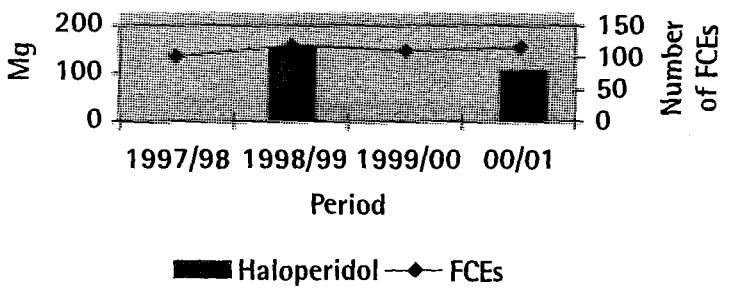


Figure 4.3 Midazolam use – Daedalus ward

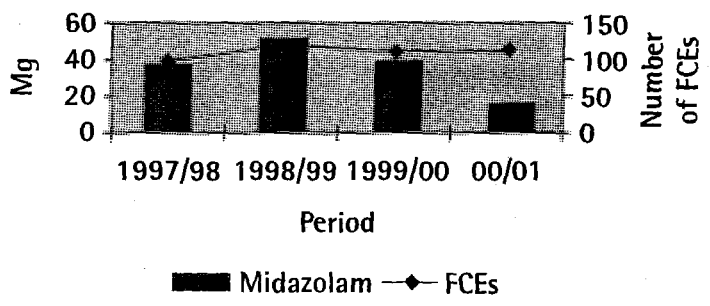


Figure 4.4 Diamorphine use – Dryad ward

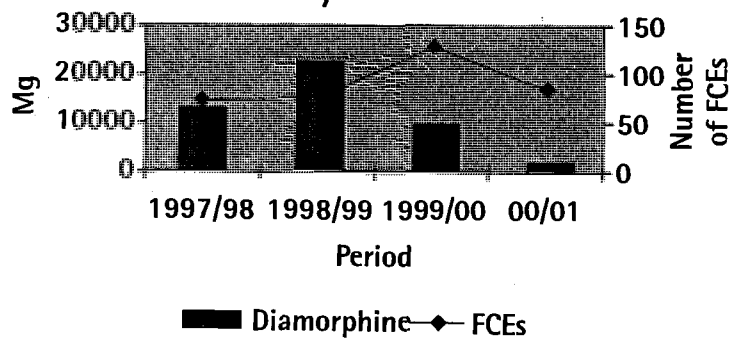


Figure 4.5 Haloperidol use – Dryad ward

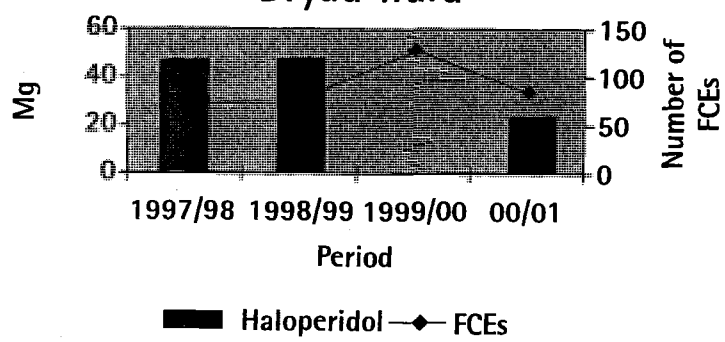


Figure 4.6 Midazolam use – Dryad ward

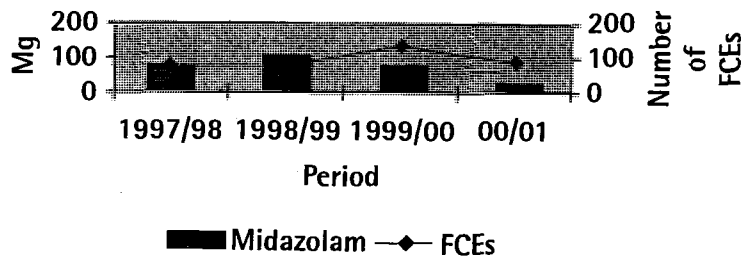


Figure 4.7 Diamorphine use – Sultan ward

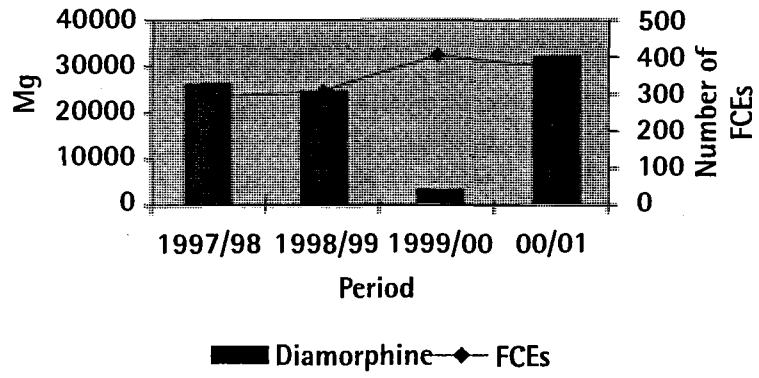


Figure 4.8 Haloperidol use – Sultan ward

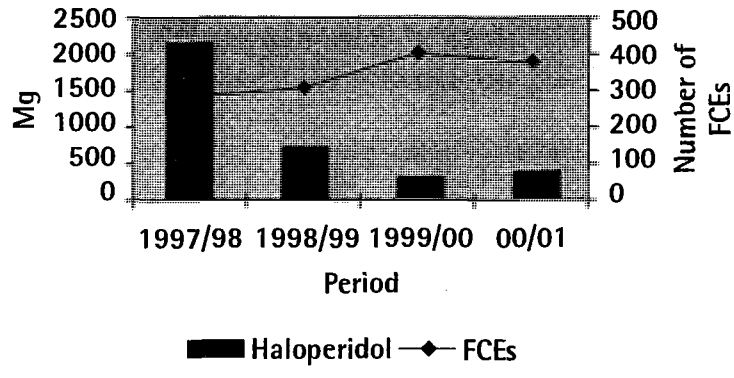
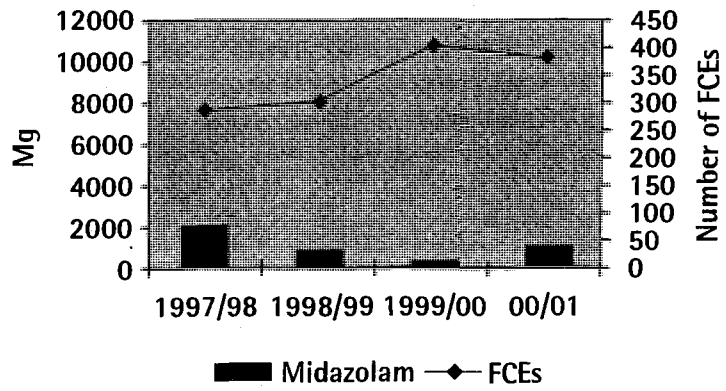


Figure 4.9 Midazolam use – Sultan ward



Assessment and management of pain

4.6 Part of the individual total assessment of each patient includes an assessment of any pain they may be experiencing and how this is to be managed. In 1998, the trust did not have a policy for the assessment and management of pain. This was introduced in April 2001, in collaboration with Portsmouth Hospitals NHS Trust, and is due for review in 2003. The stated purpose of the document was to identify mechanisms to ensure that all patients have early and effective management of pain or distress. The policy placed responsibility for ensuring that pain management standards are implemented in every clinical setting and sets out the following:

- the prescription must be written by medical staff following diagnosis of type(s) of pain and be appropriate given the current circumstances of the patient
- if the prescription states that medication is to be administered by continuous infusion (syringe driver), the rationale for this decision must be clearly documented
- all prescriptions for drugs administered via a syringe driver must be written on a prescription sheet designed for this purpose

4.7 CHI has also seen evidence of a pain management cycle chart and an 'analgesic ladder'. The analgesic ladder indicates the drug doses for different levels and types of pain, how to calculate opiate doses, gives advice on how to evaluate the effects of analgesia and how to observe for any side effects. Nurses interviewed by CHI demonstrated a good understanding of pain assessment tools and the use of the analgesic ladder.

4.8 CHI was told by some nursing staff that following the introduction of the policy, it took longer for some patients to become pain free and that medical staff were apprehensive about prescribing diamorphine. Nurses also spoke of a reluctance of some patients to take pain relief. CHI's case note review concluded that two of the 15 patients reviewed were not prescribed adequate pain relief for part of their stay in hospital.

4.9 Many staff interviewed referred to the "Wessex guidelines". This is a booklet called *Palliative care handbook guidelines on clinical management* drawn up by Portsmouth Healthcare NHS Trust, the Portsmouth Hospitals NHS Trust and a local hospice, in association with the Wessex palliative care units. These guidelines were in place in 1998. Although the section on pain focuses on patients with cancer, there is a clear highlighted statement in the guidelines that states "all pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold".

4.10 The Wessex guidelines are comprehensive and include detail, in line with British National Formulary recommendations, on the use, dosage, and side effects of medicines commonly used in palliative care. The guidelines are not designed for a rehabilitation environment.

4.11 CHI's random case note review of 15 recent admissions concluded that the pain assistance and management policy is being adhered to. CHI was told by staff of the previous practice of anticipatory prescribing of palliative opiates. As a result of the pain and assessment policy, this practice has now stopped.

Prescription writing policy

4.12 This policy was produced jointly with the Portsmouth Hospitals NHS Trust in March 1998. The policy covered the purpose, scope, responsibilities and requirements for prescription writing, medicines administered at nurses' discretion and controlled drugs. A separate policy covers the administration of intravenous medicines.

4.13 The policy has a section on verbal prescription orders, including telephone orders, in line with UKCC guidelines. CHI understands that arrangements such as these are common practice in GP led wards and work well on the Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours. These arrangements were also confirmed by evidence found in CHI's case note review.

Administration of medicines

4.14 Medicines can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and via a syringe driver. Some of the medicines used in the care of older people can be delivered by a syringe driver, which delivers a continuous subcutaneous infusion of medication. Syringe drivers can be an entirely appropriate method of medicine administration that provides good control of symptoms with little discomfort or inconvenience to the patient. Guidance for staff on prescribing via syringe drivers is contained within the trust's policy for assessment and management of pain. The policy states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

4.15 Evidence from CHI's case note review demonstrated good documented examples of communication with both patients and relatives over medication and the use of syringe drivers and the application of the trust's policy.

4.16 Information provided by the trust indicates that only two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five nurses had also completed a drugs competencies course. No qualified nurses from Dryad or Daedalus ward had taken part in either course between 1998 and 2001. Some nursing and healthcare support staff spoke of receiving syringe driver information and training from a local hospice.

Role of nurses in medicines administration

4.17 Registered nurses are regulated by the Nursing and Midwifery Council, a new statutory body which replaced the United Kingdom Central Council on 1 April 2002. Registered nurses must work within their code of professional conduct (UKCC, June 1992). The scope of professional practice clarified the way in which registered nurses are personally accountable for their own clinical practice and for care they provide to patients. The standards for the administration of medicines (UKCC, October 1992) details what is expected of nurses carrying out this function.

4.18 Underpinning all of the regulations that govern nursing practice, is the requirement that nurses act in the best interest of their patients at all times. This could include challenging the prescribing of other clinical staff.

Review of medicines

4.19 The regular ward rounds and multidisciplinary meetings should include a review of medication by senior staff, which is recorded in the patient's case notes. CHI recognises the complexity of multidisciplinary meetings. Despite this, a process should be found to ensure that effective and regular reviews of patient medication take place by senior clinicians and pharmacy staff.

Structure of pharmacy

4.20 Portsmouth Healthcare NHS Trust has a service level agreement for pharmacy services with the local acute trust, Portsmouth Hospitals NHS Trust. An E grade pharmacist manages the contract locally and the service provided by a second pharmacist, who is the lead for older peoples' services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing workload. Pharmacy staff were confident that ward pharmacists would now challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to put the trust's *A compendium of drug therapy guidelines* on the intranet, although this is not easily available to all staff.

4.21 Pharmacy training for non pharmacy staff was described as "totally inadequate" and not taken seriously. Nobody knew of any training offered to clinical assistants.

4.22 There were no systems in place in 1998 for the routine review of pharmacy data which could have alerted the trust to any unusual or excessive patterns of prescribing, although the prescribing data was available for analysis.

KEY FINDINGS

1. CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing (the "Wessex guidelines") but this was inappropriately applied to patients admitted for rehabilitation.

2. Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.

3. The usage of diamorphine, midazolam and haloperidol has declined in recent years, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998.

4. CHI found some evidence to suggest a recent reluctance amongst clinicians to prescribe sufficient pain relieving medication. Despite this, diamorphine usage on Sultan ward 2000/2001 showed a marked increase.

5. CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Anticipatory prescribing is no longer evident on these wards. Although the palliative care Wessex guidelines refer to non physical symptoms of pain, the trust's policies do not include methods of non verbal pain assessment and rely on the patient articulating when they are in pain.

6. CHI found little evidence to suggest that thorough individual total patient assessments were being made by multidisciplinary teams in 1998. CHI's case note review concluded that this approach to care had been developed in recent years.

7. Pharmacy support to the wards in 1998 was inadequate. The trust was able to produce pharmacy data in 2002 relating to 1998. A system should have been in place to review and monitor prescribing at ward level, using data such as this as a basis.

RECOMMENDATIONS

1. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

2. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

3. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

4. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

5 | Quality of care and the patient experience

Introduction

5.1 This chapter details CHI's findings following contact with patients and relatives. This needs to be put into the context of the 1,725 finished consultant episodes for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Details of the methods used to gain an insight into the patient experience and of the issues raised with CHI are contained in appendix B.

Patient expeience

5.2 As with all patients being cared for when they are sick and vulnerable, it is important to treat each person as a whole. For this reason, the total holistic assessment of patients is critical to high quality individual care tailored to each patient's specific needs. The following sections are key elements (though not an exhaustive list) of total assessments which were reported to CHI by stakeholders.

5.3 CHI examined in detail the experience of older patients admitted to the Gosport War Memorial Hospital between 1998 and 2001 and that of their relatives and carers. This was carried out in two ways. Firstly, stakeholders were invited, through local publicity, to make contact with CHI. The police also wrote to relatives who had expressed concern to them informing them of CHI's investigation. Views were invited in person, in writing, over the telephone and by questionnaire. A total of 36 patients and relatives contacted CHI during the investigation.

5.4 Secondly, CHI made a number of observation visits, including at night, to Daedalus, Dryad and Sultan wards during the site visit week in January 2002. Some of the visits were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed.

Stakeholder views

5.5 The term stakeholder is used by CHI to define a range of people that are affected by, or have an interest in, the services offered by an organisation. CHI heard of a range of both positive and less positive experiences, of the care of older people. The most frequently raised concerns with CHI were: the use of medicines, the attitude of staff, continence management, the use of patients' own clothing, transfer arrangements between hospitals and nutrition and fluids. More detail on each of these areas is given below.

5.6 Relatives expressed concern around a perceived lack of nutrition and fluids as patients neared the end of their lives: "no water and fluids for last four days of life". Comments were also raised about unsuitable, unappetising food and patients being left to eat without assistance. A number of stakeholders commented on untouched food being cleared away without patients being given assistance to eat.

5.7 Following comments by stakeholders, CHI reviewed the trust policy for nutrition and fluids. The trust conducted a trust wide audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy *Feeding People*. The trust policy, *Prevention and management of malnutrition* (2000), included the designation of an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure full compliance. The standards state:

- all patients must have a nutritional risk assessment on admission
- registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary
- all staff must ensure that documented evidence supports the continuity of patient care and clinical practice
- all clinical areas should have a nominated nutritional representative who attends training/updates and is a resource for colleagues
- systems should be in place to ensure that staff have the required training to implement and monitor the *Feeding People* standards

5.8 A second trust audit in 2000 concluded that, overall, the implementation of the *Feeding People* standards had been "very encouraging". However, there were concerns about the lack of documentation and a sense of complacency as locally written protocols had not been produced throughout the service.

5.9 CHI's review of recent case notes concluded that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses appeared unable to make swallowing assessments out of hours; this could lead to delays in receiving nutrition over weekends, for example, when speech and language therapy staff were not available.

5.10 Continence management is an important aspect of the care of older people, the underlying objective is to promote or sustain continence as part of the holistic management of care, this includes maintaining skin integrity (prevention of pressure sores). Where this is not possible, a range of options including catheterisation are available and it is imperative that these are discussed with patients, relatives and carers. Some stakeholders raised concerns regarding the 'automatic' catheterisation of patients on admission to the War Memorial. "They seem to catheterise everyone. My husband was not incontinent; the nurse said it was done mostly to save time". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.

5.11 CHI's review of recent case notes found no evidence of inappropriate catheterisation of patients in recent months.

5.12 The use of pain relieving medicines and the use of syringe drivers to administer them was commented on by a number of relatives. One relative commented that her mother "certainly was not in pain prior to transfer to the War Memorial". Although a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI also received comments that families would have liked more information: "Doctors should disclose all drugs, why [they are being used] and what the side effects are. There should be more honesty".

5.13 Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by their families. "They were never in their own clothes". Relatives also thought patients being dressed in other patients' clothes was a potential cross infection risk. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes. This is an important means by which patients' dignity can be maintained.

5.14 Concern was expressed regarding the physical transfer of patients from one hospital to another. Amongst concerns were lengthy waits prior to transfer, inadequate clothing and covering during the journey and the methods used to transfer patients. One person described their relative as being "carried on nothing more than a sheet". CHI learnt that this instance was acknowledged by Portsmouth Healthcare NHS Trust, who sought an apology from the referring hospital, which did not have the appropriate equipment available.

5.15 Though there were obvious concerns regarding the transfer of patients, during the period of the investigation, the Hampshire Ambulance Service NHS Trust, who were responsible for patient transfers between hospitals, received no complaints relating to the transfer of patients to and from the Gosport War Memorial Hospital.

5.16 Comments about the attitude of staff ranged from the very positive "Everyone was so kind and caring towards him in both Daedalus and Dryad wards" and "I received such kindness and help from all the staff at all times" to the less positive "I was made to feel an inconvenience because we asked questions" and "I got the feeling she had dementia and her feelings didn't count".

Outcome of CHI observation work

5.17 CHI spent time on Dryad, Sultan and Daedalus wards throughout the week of 7 January 2002 to observe the environment in which care was given, the interactions between staff and patients and between staff. Ward staff were welcoming, friendly and open. Although CHI observed a range of good patient experiences this only provides a 'snap shot' during the site visit and may not be fully representative. However, many of the positive aspects of patient care observed were confirmed by CHI's review of recent patient notes.

Ward environment

5.18 All wards were built during the 1991 expansion of the hospital and are modern, welcoming and bright. This view was echoed by stakeholders, who were complimentary about the décor and patient surroundings. Wards were tidy, clean and fresh smelling.

5.19 Day rooms are pleasant and Daedalus ward has direct access to a well designed garden suitable for wheelchair users. The garden is paved with a variety of different textures to enable patients to practice mobility. There is limited storage space in Daedalus and Dryad wards and, as a result, the corridors had become cluttered with equipment. This can be problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe.

5.20 CHI saw staff address patients by name in a respectful and encouraging way and saw examples of staff helping patients with dressing and holding friendly conversations. The staff handovers observed were well conducted, held away from the main wards areas and relevant information about patient care was exchanged appropriately.

5.21 Mealtimes were well organised with patients given a choice of menu options and portion size. Patients who needed help to eat and drink were given assistance. There appeared to be sufficient staff to serve meals, and to note when meals were not eaten. CHI did not observe any meals returned untouched. Healthcare support workers told CHI that they were responsible for making a note when meals were not eaten.

5.22 There are day rooms where patients are able to watch the television and large print books, puzzles and current newspapers are provided. CHI saw little evidence of social activities taking place, although some patients did eat together in the day room. Bells to call assistance are situated by patients' beds, but are less accessible to patients in the day rooms. The wards have an activities coordinator, although the impact of this post has been limited.

5.23 Daedalus ward has a communication book by each bed for patients and relatives to make comments about day to day care. This is a two way communication process which, for example, allows therapy staff to ask relatives for feedback on progress and enables relatives to ask for an appointment with the consultant.

5.24 CHI observed two medicine rounds, both of which were conducted in an appropriate way with two members of staff jointly identifying the patient and checking the prescription sheet. One member of staff handed out the medicines while the other oversaw the patients as medicines are taken. Medicines are safely stored on the wards in locked cupboards.

Communication with patients, relatives and carers

The trust had an undated user involvement service development framework, which sets out the principles behind effective user involvement within the national policy framework described in the NHS Plan. It is unclear from the framework who was responsible for taking the work forward and within what time frame. Given the dissolution of the trust, a decision was taken not to establish a trust wide Patient Advice and Liaison Service (PALS), a requirement of the NHS Plan. However, work was started by the trust to look at a possible future PALS structure for the Fareham and Gosport PCT.

The Health Advisory Service *Standards for health and social care services for older people* (2000) states that "each service should have a written information leaflet or guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers". CHI saw a number of separate information leaflets provided for patients and relatives during the site visit.

The trust used patient surveys, given to patients on discharge, as part of its patient involvement framework, although the response rate was unknown. Issues raised by patients in completed surveys were addressed by action plans discussed at clinical managers meetings. Ward specific action plans were distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, thermometers were purchased to address the problem. CHI could find no evidence to suggest that the findings from patient surveys were shared across the trust.

Support towards the end of life

Staff referred to the Wessex palliative care guidelines, which are used on the wards and address breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure on Queen Alexandra and St Mary's hospitals to "discharge patients too quickly to Gosport War Memorial Hospital". Staff were aware of increased numbers of medically unstable patients being transferred in recent years.

Both patients and relatives have access to a hospital chaplain, who has links to representatives of other faiths. The trust had a leaflet for relatives *Because we care* which talks about registering the death, bereavement and grieving. The hospital has a designated manager to assist relatives through the practical necessities following a death.

KEY FINDINGS

1. Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.

2. Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

3. The ward environments and patient surroundings are good.

4. Some notable steps had been taken on Daedalus ward to facilitate communication between patients and their relatives with ward staff.

5. CHI was concerned, following the case note review, of the inability of any ward staff to undertake swallowing assessments as required. This is an area of potential risk for patients whose swallowing reflex may have been affected, for example, by a stroke.

6. Opportunities for patients to engage in daytime activities in order to encourage orientation and promote confidence are limited.

7. The trust had a strong theoretical commitment to patient and user involvement.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

2. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

3. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

4. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

5. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

6 | Staffing arrangements and responsibility for patient care

Responsibility for patient care

6.1 Patient care on Daedalus and Dryad wards at Gosport War Memorial Hospital for the period of the CHI investigation was provided by consultant led teams. A multidisciplinary, multiprofessional team of appropriately trained staff best meets the complex needs of these vulnerable patients. This ensures that the total needs of the patient are considered and are reflected in a care plan, which is discussed with the patient and their relatives and is understood by every member of the team.

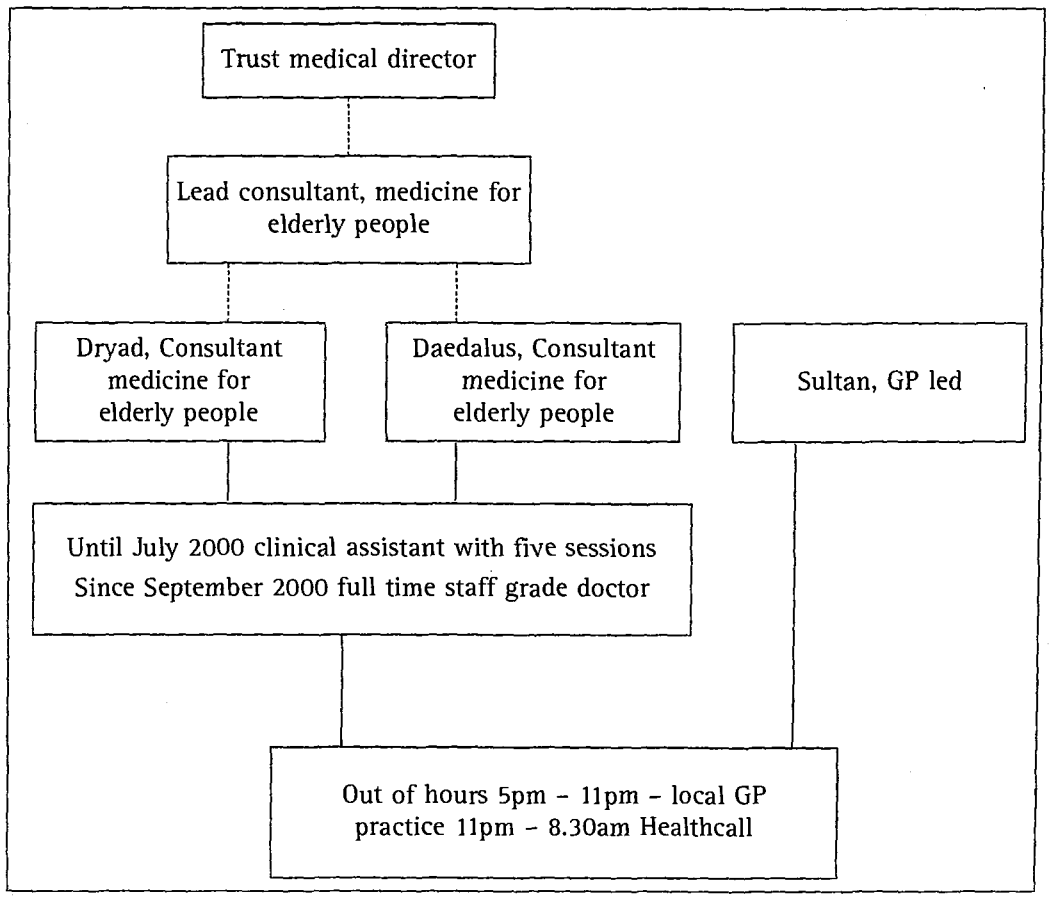
Medical responsibility

6.2 For the period covered by the CHI investigation, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. This is still the case today. All patients on both wards are admitted under the care of a consultant. Since 1995, there has been a lead consultant for the department of medicine for elderly people who held a two session contract (one session equates to half a day per week) for undertaking lead consultant responsibilities. These responsibilities included overall management of the department and the development of departmental objectives. The lead consultant is not responsible for the clinical practice of individual doctors. The post holder does not undertake any clinical sessions on the War Memorial site. The job description for the post, outlines 12 functions and states that the post is a major challenge for "a very part time role".

6.3 Since 2000, two department of elderly medicine consultants provide a total of 10 sessions of consultant cover on Dryad and Daedalus wards per week. Since September 2000, day to day medical support has been provided by a staff grade physician who was supervised by both consultants. Until July 2000, a clinical assistant provided additional medical support. Both consultants currently undertake a weekly ward round with the staff grade doctor. In 1998, there was a fortnightly ward round on Daedalus ward. On Dryad, ward rounds were scheduled fortnightly, though occurred less frequently.

6.4 CHI feels that the staff grade post is a pivotal, potentially isolated post, due to the distance of Gosport War Memorial Hospital from the main department of medicine for elderly people based at Queen Alexandra Hospital, no full time support from medical colleagues on the wards and a difficulty in attending departmental meetings. In 2001, the trust identified the risk of professional isolation and lack of support at Gosport War Memorial Hospital as a reason not to appoint a locum consultant.

Figure 6.1 Line management accountabilities



(*---------- this line indicates managerial accountability and not clinical accountability)

General practice role and accountability

6.5 Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation: as clinical assistants employed by the trust, as the clinicians admitting and caring for patients on the GP ward (Sultan) and as providers of out of hours medical support to all patients on each of the three wards.

Clinical assistant role

6.6 Clinical assistants are usually GPs employed and paid by trusts, largely on a part time basis, to provide medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years. Portsmouth Healthcare NHS Trust employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants work as part of a consultant led team and have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

6.7 From 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states that the clinical assistant was accountable to "named consultant physicians in geriatric medicine". The post holder was responsible for arranging cover for annual leave and any sickness absence with practice partners. The trust and the practice partners did not have a contract for this work. The job description does state that the post is subject to the terms and conditions of hospital medical and dental staff. Therefore, any concerns over the performance of any relevant staff could be pursued through the trust's disciplinary processes. CHI could find no evidence to suggest that this option was considered at the time of the initial police investigation in 1998.

Appraisal and supervision of clinical assistants

6.8 CHI is not aware of any trust systems in place to monitor or appraise the performance of clinical assistants in 1998. This lack of monitoring is still common practice within the NHS. The consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, had no system for supervising the practice of the clinical assistant, including any review of prescribing. CHI found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions.

6.9 CHI is aware of work by the Department of Health on GP appraisal which will cover GPs working as clinical assistants and further work to develop guidance on disciplinary procedures.

Sultan ward

6.10 Medical responsibility for patients on Sultan ward lay with the admitting GP throughout the period of the CHI investigation. The trust issued admitting GPs with a contract for working on trust premises, which clearly states "you will take full clinical responsibility for the patients under your care". CHI was told that GPs visit their patients regularly as well as when requested by nursing staff. This is a common arrangement in community hospitals throughout the NHS. GPs had no medical accountablity framework within the trust.

6.11 GPs managing their own patients on Sultan ward could be subject to the health authority's voluntary process for dealing with doctors whose performance is giving cause for concern. However, this procedure can only be used in regard to their work as a GP, and not any contracted work performed in the trust as a clinical assistant. Again, this arrangement is common throughout the NHS.

Out of hours cover provided by GPs

6.12 Between the hours of 8.30am and 5.00pm on weekdays, hospital doctors employed by the trust manage the care of all patients on Dryad and Daedalus wards. Out of hours medical cover, including weekends and bank holidays, is provided by a local GP practice from 5.00pm to 11.00pm, after which, between 11.00pm and 8.30am, nursing staff call on either the patient's practice or Healthcall, a local deputising service for medical input. If an urgent situation occurs out of hours, staff call 999 for assistance.

6.13 Some staff interviewed by CHI expressed concern about long waits for the deputising service, CHI heard that waiting times for Healthcall to attend a patient could sometimes take between three and five hours. However, evidence provided by Healthcall contradicts this. Nurses expressed concern over Healthcall GPs' reluctance to 'interfere' with the prescribing of admitting GPs on Sultan and Dryad wards. The contract with Healthcall is managed by a local practice.

Appraisal of hospital medical staff

6.14 Since April 2000, all NHS employers have been contractually required to carry out annual appraisals, covering both clinical and non clinical aspects of their jobs. All doctors interviewed by CHI who currently work for the trust, including the medical director, who works five sessions in the department of medicine for elderly people, have regular appraisals. Those appraising the work of other doctors have been trained to do so.

Nursing responsibility

6.15 All qualified nurses are personally accountable for their own clinical practice. Their managers are responsible for implementing systems and environments that promote high quality nursing care.

6.16 On each ward, a G grade clinical manager, who reports to a senior H grade nurse, manages the ward nurses. The H grade nurse covers all wards caring for older people and was managed by the general manager for the Fareham and Gosport division. The general manager reported to both the director of nursing and the operations director. An accountability structure such as this is not unusual in a community hospital. The director of nursing was ultimately accountable for the standard of nursing practice within the hospital.

Nursing supervision

6.17 Clinical supervision for nurses was recommended by the United Kingdom Central Council in 1996 and again in the national nursing strategy, *Making a difference*, in 1999. It is a system through which qualified nurses can maintain lifelong development and enhancement of their professional skills through reflection, exploration of practice and identification of issues that need to be addressed. Clinical supervision is not a

managerial activity, but provides an opportunity to reflect and improve on practice in a non judgemental environment. Clinical supervision is a key factor in professional self regulation.

6.18 The trust has been working to adopt a model of clinical supervision for nurses for a number of years and received initial assistance from the Royal College of Nursing to develop the processes. As part of the trust's clinical nursing development programme, which ran between January 1999 and December 2000, nurses caring for older people were identified to lead the development of clinical supervision on the wards.

6.19 Many of the nurses interviewed valued the principles of reflective practice as a way in which to improve their own skills and care of patients. The H grade senior nurse coordinator post, appointed in November 2000, was a specific trust response to an acknowledged lack of nursing leadership at the Gosport War Memorial Hospital.

Teamworking

6.20 Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. Staff interviewed by CHI spoke of teamwork, although in several instances this was uniprofessional, for example a nursing team. CHI observed a multidisciplinary team meeting on Daedalus ward, which was attended by a consultant, a senior ward nurse, a physiotherapist and an occupational therapist. No junior staff were present. Hospital staff described input from social services as good when available, though this was not always the case.

6.21 Regular ward meetings are held on Sultan and Daedalus wards. Arrangements are less clear on Dryad ward, possibly due to the long term sickness of senior ward staff.

6.22 Arrangements for multidisciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multidisciplinary goal setting for patients, but were hopeful of further development.

Allied health professional structures

6.23 Allied health professionals are a group of staff which include occupational therapists, dieticians, speech and language therapists and physiotherapists. The occupational therapy structure is in transition from a traditional site based service to a defined clinical specialty service (such as stroke rehabilitation) in the locality. Staff explained that this system enables the use of specialist clinical skills and ensures continuity of care of patients, as one occupational therapist follows the patient throughout hospital admission(s) and at home. Occupational therapists talking to CHI described a good supervision structure, with supervision contracts and performance development plans in place.

6.24 Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right through to home treatment. Physiotherapists described good levels of training and supervision and involvement in Daedalus ward's multidisciplinary team meetings.

6.25 Speech and language therapists also reported participation in multidisciplinary team meetings on Daedalus ward. Examples were given to CHI of well developed in service training opportunities and professional development, such as discussion groups and clinical observation groups.

6.26 The staffing structure in dietetics consists of one full time dietitian based at St James Hospital. Each ward has a nurse with lead nutrition responsibilities able to advise colleagues.

Workforce and service planning

6.27 In November 2000, in preparation for the change of use of beds in Dryad and Daedalus wards from continuing care to intermediate care, the trust undertook an undated resource requirement analysis and identified three risk issues:

- consultant cover
- medical risk with a change in patient group and the likelihood of more patients requiring specialist intervention. The trust believed that the introduction of automated defibrillators would go some way to resolve this. The paper also spoke of "the need for clear protocols...within which medical cover can be obtained out of hours"
- the trust identified a course for qualified nursing staff, ALERT, which demonstrates a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration

6.28 Despite this preparation, several members of staff expressed concern to CHI regarding the complex needs of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages and high sickness levels. Concerns were raised formally with the trust in early 2000 around the increased workload and complexity of patients. This was acknowledged in a letter by the medical director. CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix, though a full time staff grade doctor was in post by September 2002 to replace and increase the previous five sessions of clinical assistant cover.

Access to specialist advice

6.29 Older patients are admitted to Gosport War Memorial Hospital with a wide variety of physical and mental health conditions, such as strokes, cancers and dementia. Staff demonstrated good examples of systems in place to access expert opinion and assistance.

6.30 There are supportive links with palliative care consultants, consultant psychiatrists and oncologists. The lead consultant for elderly mental health reported close links with the three wards, with patients either given support on the ward or transfer to an elderly mental health bed. There are plans for a nursing rotation

programme between the elderly medicine and elderly mental health wards. Staff spoke of strong links with the local hospice and Macmillan nurses. Nurses gave recent examples of joint training events with the hospice.

6.31 CHI's audit of recent case notes indicated that robust systems are in place for both specialist medical advice and therapeutic support.

Staff welfare

6.32 Since its creation in 1994, the trust developed as a caring employer, demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy that has won national recognition. The hospital was awarded Investors in People status in 1998. Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship.

6.33 However, many staff, at all levels in the organisation, spoke of the stress and low morale caused by the series of police investigations and the referrals to the General Medical Council, the United Kingdom Central Council and the CHI investigation. Trust managers told CHI they encouraged staff to use the trust's counselling service and support sessions for staff were organised. Not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, "I don't feel I've had the support I should have had before and during the police investigation – others feel the same".

Staff communication

6.34 Most staff interviewed by CHI spoke of good internal communications, and were well informed about the transfer of services to PCTs. The trust used newsletters to inform staff of key developments. An intranet is being developed by the Fareham and Gosport PCT to facilitate communication with staff.

KEY FINDINGS

1. Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards. It was not made clear to CHI how GPs working as clinical assistants and admitting patients to Sultan wards are included in the development of trust procedures and clinical governance arrangements.

2. There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff. Currently, there is effective nursing leadership on Daedalus and Sultan wards, this is less evident on Dryad ward. CHI was concerned regarding the potential for professional isolation of the staff grade doctor.

3. Systems are now in place to ensure that appropriate specialist medical and therapeutic advice is available for patients. Some good progress has been made towards multidisciplinary team working which should be developed.

4. There was a planned approach to the service development in advance of the change in use of beds in 2000. The increasing dependency of patients and resulting pressure on the service, whilst recognised by the trust, was neither monitored nor reviewed as the changes were implemented and the service developed.

5. Portsmouth Healthcare NHS Trust should be congratulated for its progress towards a culture of reflective nursing practice.

6. The trust has a strong staff focus, with some notable examples of good practice. Despite this, CHI found evidence to suggest that not all staff felt adequately supported during the police and other recent investigations.

7. Out of hours medical cover for the three wards out of hours is problematic and does not reflect current levels of patient dependency.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangemnts, clinical governance responsibilities and trianing needs.

2. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

3. Fareham and Gosport PCT and East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

4. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

5. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

7 | Lessons learnt from complaints

7.1 A total of 129 complaints were made regarding the provision of elderly medicine since 1 April 1997. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra hospitals. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

7.2 Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. Three complaints in the last five months of 1998 expressed concern regarding pain management, the use of diamorphine and levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients, was considered by the police expert witnesses.

External review of complaints

7.3 One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical adviser found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 was referred to an independent review panel, which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Although the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

Complaint handling

7.4 The trust had a policy for handling patient related complaints produced in 1997 and reviewed in 2000, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure.* A leaflet for patients detailing the various stages of the complaints procedure was produced, which indicated the right to request an independent review if matters were not satisfactorily resolved together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards during CHI's visit.

7.5 Both the trust and the local community health council (CHC) described a good working relationship. The CHC regretted, however, that their resources since November 2000 had prevented them from offering the level of advice and active support to trust complainants they would have wished. The CHC did continue to support complainants who had contacted them before November 2000. New contacts were provided with a "self help" pack.

7.6 CHI found that letters to complainants in response to their complaints did not always include an explanation of the independent review stage, although this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. The 2000 update of the complaints policy stated that audit standards for complaints handling were good with at least 80% of complainants satisfied with complaint handling and 100% of complaints resolved within national performance targets. The chief executive responded to all written complaints. Staff interviewed by CHI valued the chief executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services.

7.7 Once the police became involved in the initial complaint in 1998, the trust ceased its internal investigation processes. CHI found no evidence in agendas and minutes that the trust board were formally made aware of police involvement. Senior trust managers told CHI that the trust would have commissioned a full internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not preclude full internal clinical investigation. CHI was told that neither the doctor nor portering staff involved in the care and transfer of the patient whose care was the subject of the initial police investigation were asked for statements during the initial complaint investigation.

Trust learning regarding prescribing

7.8 Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter 4). In addition, CHI learnt that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem". This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20mg to 40mg per day.

7.9 Portsmouth Healthcare NHS Trust correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mg a day. CHI understands this protocol to be the Wessex guidelines. Further correspondence in October 1999, indicated that a doctor working on the wards requested a trust policy on the prescribing of opiates in community hospitals.

7.10 A draft protocol for the prescription and administration of diamorphine by subcutaneous infusion was piloted on Dryad ward in 1999 and discussed at the trust's Medicines and Prescribing Committee in February and April 2000 following consultation with palliative care consultants. This guidance was eventually incorporated into the joint Portsmouth Healthcare NHS Trust and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain which was introduced in April 2001.

Other trust lessons

7.11 Lessons around issues other than prescribing have been learnt by the trust, though the workshop to draw together this learning was not held until early 2001 when the themes discussed were communication with relatives, staff attitudes and fluids and nutrition. Action taken by the trust since the series of complaints in 1998 are as follows:

- an increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999
- the appointment of a full time staff grade doctor in September 2000 which increased medical cover following the resignation of the clinical assistant
- piloting pain management charts and prescribing guidance approved in April 2001. Nursing documentation is currently under review, with nurse input
- one additional consultant session began in 2000, following a district wide initiative with local PCGs around intermediate care
- nursing documentation now clearly identifies prime family contacts and next of kin information to ensure appropriate communication with relatives
- all conversations with families are now documented in the medical record. CHI's review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff

7.12 Comments recorded in this workshop were echoed by staff interviewed by CHI, such as the difficultly in building a rapport with relatives when patients die a few days after transfer, the rising expectations of relatives and the lack of control Gosport War Memorial staff have over information provided to patients and relatives prior to transfer regarding longer term prognosis.

Monitoring and trend identification

7.13 A key action identified in the 2000/2001 clinical governance action plan was a strengthening of trust systems to ensure that actions following complaints were implemented. Until the dissolution of Portsmouth Healthcare NHS Trust, actions were monitored through the divisional review process, the clinical governance panel and trust board. A trust database was introduced in 1999 to record and track complaint trends. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

7.14 Portsmouth Healthcare NHS Trust offered specific training in complaints handling, customer care and loss, death and bereavement, which many staff interviewed by CHI were aware of and had attended.

KEY FINDINGS

1. The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake an review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation which it was aware of in late 1998.

2. Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

3. Though Portsmouth Healthcare NHS Trust did begin to develop a protocol for the prescription and administration of diamorphine by syringe driver in 1999, the delay in finalising this protocol in April 2001, as part of the policy for the assessment and management of pain, was unacceptable.

4. There has been some, but not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

RECOMMENDATIONS

1. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

2. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

3. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

8 | Clinical governance

Introduction

8.1 Clinical governance is about making sure that health services have systems in place to provide patients with high standards of care. The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

8.2 CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems supported the delivery of continuing and rehabilitative inpatient care for older people at the Gosport War Memorial Hospital. This chapter sets out the framework and structure adopted by the trust between 1998 and 2002 to deliver the clinical governance agenda and details those areas most relevant to the terms of reference for this investigation: risk management and the systems in place to enable staff to raise concerns.

Clinical governance structures

8.3 The trust reacted swiftly to the principles of clinical governance outlined by the Department of Health in *A First Class Service* by devising an appropriate management framework. In September 1998, a paper outlining how the trust planned to develop a system for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff interviewed by CHI were aware of the principles of clinical governance and were able to demonstrate how it related to them in their individual roles. Understanding of some specific aspects, particularly risk management and audit, was patchy.

8.4 The medical director took lead responsibility for clinical governance and chaired the clinical governance panel, a sub committee of the trust board. A clinical governance reference group, whose membership included representatives from each clinical service, professional group, non executive directors and the chair of the community health council, supported the clinical governance panel. Each clinical service also had its own clinical governance committee. This structure had been designed to enable each service to take clinical governance forward into whichever PCT it found itself in after April 2002. Since February 2000, the trust used the divisional review process to monitor clinical governance developments.

8.5 The service specific clinical governance committees were led by a designated clinician and included wide clinical and professional representation. Baseline assessments were carried out in each specialty and responsive action plans produced. The medical director and clinical governance manager attended divisional review meetings and reported key issues back to the clinical governance panel.

8.6 District Audit carried out an audit of the trust's clinical governance arrangements in 1998/1999. The report, dated December 1999, states that the trust had fully complied with requirements to establish a framework for clinical governance. The report also referred to the trust's document, *Improving quality – steps towards a first class service*, which was described as "of a high standard and reflected a sound understanding of clinical governance and quality assurance".

8.7 Whilst commenting favourably on the framework, the District Audit review also noted the following:

- the process for gathering user views should be more focused and the process strengthened
- the trust needed to ensure that in some areas, strategy, policy and procedure is fed back to staff and results in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and reaudited; lessons learnt from complaints and incidents not always used to change practice and that research and development did not always lead to change in practice
- more work needed to be done with clinical staff on openness and the support of staff alerting senior management of poor performance

8.8 Following the review, the trust drew up a trust wide action plan (December 1999) which focused on widening the involvement and feedback from nursing, clinical and support staff regarding trust protocols and procedures, and on making greater use of research and development, clinical audit, complaints, incidents and user views to lead to changes in practice. CHI was told of a link nurse programme to take elements of this work forward.

Risk management

8.9 A trust risk management group was established in 1995 to develop and oversee the implementation of the trust's risk management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The group had links with other trust groups such as the clinical and service audit group, the board and the nursing clinical governance committee. Originally the finance director had joint responsibility for strategic risk with the quality manager; this was changed in the 2000/2003 strategy when the medical director became the designated lead for clinical risk. The trust achieved the clinical negligence scheme for trusts (CNST) level one in 1999. A decision was taken not to pursue the level two standard assessment due to dissolution of the trust in 2002.

8.10 The trust introduced an operational policy for recording and reviewing risk events in 1994. New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non clinical risk. The same trust policy was used to report clinical and non clinical risks and accidents. All events were recorded in the trust's risk event database (CAREKEY). This reporting system was also used for near misses and medication errors. Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, although CHI was less confident that medical staff regularly identified and reported risks. CHI was told that risk forms were regularly submitted by wards in the event of staff shortages. Staff shortage was not one of the trust's risk event definitions.

8.11 The clinical governance development plan for 2001/2002 stated that the focus for risk management in 2000/2001 was the safe transfer of services to successor organisations, with the active involvement of PCTs and PCGs in the trust's risk management group. Meetings were held with each successor organisation to agree future arrangements for areas such as risk event reporting, health and safety, infection control and medicines management.

Raising concerns

8.12 The trust had a whistle blowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. The policy sets out the process staff should follow if they wished to raise a concern about the care or safety of a patient "that cannot be resolved by the appropriate procedure". NHS guidance requires systems to enable concerns to be raised outside the usual management chain. Most staff interviewed were clear about how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. Fewer staff were aware of the trust's whistle blowing policy.

Clinical audit

8.13 CHI was given no positive examples of changes in patient care or prescribing as a result of clinical audit outcomes. Despite a great deal of work on revising and creating policies to support good prescribing and pain management, there was no planned audit of outcome.

8.14 CHI was made aware of two trust audits of medicines since 1998. In 1999, a review of the use of neuroleptic medicines, which includes tranquillisers such as haloperidol, within all trust elderly care continuing care wards concluded that neuroleptic medicines were not being over prescribed. The same review revealed "the weekly medical review of medication was not necessarily recorded in the medical notes". The findings of this audit and the accompanying action plan, which included guidance on completing the prescription chart correctly, was circulated to all staff on Daedalus and Dryad wards. A copy was not sent to Sultan ward. There was a reaudit in late 2001 which concluded that overall use of neuroleptic medicines in continuing care wards remained appropriate.

8.15 More recently, the Fareham and Gosport PCT has undertaken a basic audit based on the prescription sheets and medical records of patients cared for on Sultan, Dryad and Daedalus wards during two weeks in June 2002. The trust concluded "that the current prescriping of opiates, major tranquilisers and hyocine was within British National Formulary guidelines." No patients were prescribed midazolam during the audit timeframe.

KEY FINDINGS

1. The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

2. Although a system was in place to record risk events, understanding of clinical risk was not universal. The trust had a whistle blowing policy, but not all staff were aware of it. The policy did not make it sufficiently clear that staff could raise concerns outside of the usual management channels if they wished.

RECOMMENDATIONS

1. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

2. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

3. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

4. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

APPENDIX A

Documents reviewed by CHI and/or referred to in the report

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4. Intermediate care and rehabilitation services proposal, Fareham and Gosport primary care groups, May 2000.
5. Team objectives 1999/2000 – Sultan ward, Portsmouth Healthcare NHS Trust, 21 November 2001
6. Gosport War Memorial Hospital key objectives 2000/2001, 1998/1999, 1997/1998 and 1996/1997, Portsmouth Healthcare NHS Trust
7. Gosport War Memorial Hospital leaflet and general information, Portsmouth Healthcare NHS Trust, undated
8. Gosport health improvement programme (HIMP) 2000-2002, Fareham and Gosport primary care groups, undated
9. Fareham and Gosport primary care groups intermediate care and rehabilitation services, Fareham and Gosport primary care groups, undated
10. Patient throughput data from Sultan, Dryad and Daedalus wards 1997/1998 – 2000/2001, Fareham and Gosport primary care groups, April 2002
11. Fareham and Gosport staff management structure, community hospitals, Portsmouth Healthcare NHS Trust, 25 October 2001
13. Fareham and Gosport locality division structure diagram, Portsmouth Healthcare NHS Trust, 25 October 2001
14. Fareham and Gosport older persons' locality implementation group progress report. Isle of Wight, Portsmouth and South East Hants Health Authority, Fareham and Gosport primary care groups, undated
15. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
16. Correspondence from department of medicine for elderly people re: national sentinel audit of stroke 1999, Portsmouth Healthcare NHS Trust, 8 March 2000
17. Job description: Lead consultant department of medicine for elderly people (draft 4), Portsmouth Healthcare NHS Trust, February 1999
18. Job description: clinical assistant position to the geriatric division in Gosport, Portsmouth and South East Hampshire Health Authority, April 1988
19. Job description: service manager (H Grade) department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 29 August 2000
20. Job description: Service manager, community hospitals Fareham and Gosport, Portsmouth Healthcare NHS Trust, February 2000
21. University of Portsmouth, Clinical nursing governance in a department of elderly medicine: an exploration of key issues and proposals for future development, Portsmouth Healthcare NHS Trust and Portsmouth University, May 2000

22. One year on: aspects of clinical nursing governance in the department of elderly medicine, Portsmouth Healthcare NHS Trust, September 2001

23. Operational policy, bank/overtime/agency, Fareham and Gosport community hospitals and elderly mental health, Portsmouth Healthcare NHS Trust, 1 May 2001

24. Job description: full time staff grade physician, Gosport War Memorial Hospital department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 5 July 2000

25. Correspondence re: staff grade physician contract – Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 26 September 2001

26. Correspondence re: consultant in medicine for the elderly contract, Wessex Regional Health Authority, 28 January 1992

27. Essential information for medical staff department of medicine for elderly people, Portsmouth Healthcare NHS Trust, undated

28. Department of medicine for elderly people, consultant timetables August 1997-November 2001, Portsmouth Healthcare NHS Trust

29. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated

30. Information for supervision arrangements for Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, November 2001

31. Clinical managers meeting minutes, Portsmouth Healthcare NHS Trust, 12 November 2001

32. Notes of action learning meeting, Portsmouth Healthcare NHS Trust, 11 June 2001

33. Notes from team leader meetings for the Daedalus ward, Portsmouth Healthcare NHS Trust, 5 April 2001

34. Notes of Daedalus ward meeting, Portsmouth Healthcare NHS Trust, 6 August 2001

35. Fareham & Gosport locality division, nursing accountability pathway, Portsmouth Healthcare NHS Trust, 25 October 2001

36. Medical accountability structure for Gosport War Memorial Hospital, undated

37. Supervision arrangement consultant timetable at Gosport War Memorial Hospital 1998-2001, Portsmouth Healthcare NHS Trust

38. Night skill mix review Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 28 March 2001

39. Vacancy levels 1998-2001 for Sultan, Daedalus and Dryad, Portsmouth Healthcare NHS Trust, 21 November 2001

40. Sickness absence statistics for Daedalus Ward, Gosport War Memorial Hospital, 2000-2001, undated

41. Sickness absence statistics for Sultan Ward, Gosport War Memorial Hospital, 1998-2001, undated

42. Wastage for qualified nurses – Daedalus, Dryad and Sultan Ward, undated

43. Winter escalation plans elderly medicine and community hospitals, Portsmouth Healthcare NHS Trust, undated

44. Audit of detection of depression in elderly rehabilitation patients, January-November 1998, Portsmouth Healthcare NHS Trust, undated

45. District audit review of rehabilitation service for older people 2000/2001, Portsmouth Healthcare NHS Trust, January 2001

46. Memorandum to all medical staff re: rapid tranquillisation and attached protocol – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 23 February 2001

47. Correspondence re: guidelines on management of acute confusion from general manager – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 18 October 2001

48. Memorandum to all consultants from consultant geriatrician re: management of acute confusion elderly medicine, Queen Alexandra Hospital Portsmouth Healthcare NHS Trust, 30 April 2001

49. Community hospitals: guidelines for confirmation of death, Portsmouth Healthcare NHS Trust, policy date May 1998, review date May 1999

50. Memorandum: Guidelines for admission to Daedalus and Dryad ward, Portsmouth Healthcare NHS Trust, 4 October 2000

51. Clinical policy, admission and discharge policy, Portsmouth Healthcare NHS Trust, September 2000

52. Urgent notice for all medical and nursing staff in the event of a suspected fracture and/or dislocation of a patient on the above ward, Daedalus and Dryad wards, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 16 November 2001

53. Procedure for the initial management of medical emergencies in Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 15 January 2001

54. Audit of neuroleptic prescribing in elderly medicine, Portsmouth Healthcare NHS Trust, January-November 1999, November 1998-July 1999, September–December 2001

55. Administration of medicines, community hospitals – programme for updating qualified staff, Portsmouth Healthcare NHS Trust, 13 March 1997

56. Memorandum re: seminar – osteoporosis and falls, 14 November 2001, clinical assistant teaching elderly medicine, Portsmouth Healthcare NHS Trust, 19 October 2001

57. Introduction to Gosport War Memorial Hospital for staff, Portsmouth Healthcare NHS Trust, undated

58. Competence record and development for qualified nurses 1998-2001, Sultan, Dryad and Daedalus wards

59. Fareham and Gosport induction programme, 9 November 2001, Portsmouth Healthcare NHS Trust, undated

60. Training and development in community hospitals workshops – practice development facilitators (Gosport War Memorial Hospital, St Christophers Hospital, Emsworth Victoria Cottage Hospital, Petersfield Community Hospital, Havant War Memorial Hospital), East Hampshire Primary Care Trust, undated

61. Occupational therapy service – continuous professional development and training, Fareham and Gosport locality, occupational therapy professional advisor, 23 November 2001

62. Analysis of complaints at Gosport War Memorial Hospital, workshop notes and action plans, February 2001

63. Fareham and Gosport Primary Care Groups: Proposal to establish a primary care trust for Fareham and Gosport, Isle of Wight, Portsmouth and South East Hampshire Health Authority, July 2001

64. March 2001 Final monitoring report intermediate care, Portsmouth Healthcare NHS Trust, May 2001

D) DOCUMENTS RELATING TO HAMPSHIRE CONSTABULARY INVESTIGATIONS

1. Police expert witness report, Professor B Livesley, MD, FRCP, 9 November 2000
2. Police expert witness report, Professor G Ford, MA, FRCP, 12 December 2001
3. Police expert witness report, Dr K Mundy, FRCP, 18 October 2001

E) OTHER DOCUMENTS RELATING TO GOSPORT WAR MEMORIAL HOSPITAL

1. A local procedure for the identification and support of primary care medical practitioners whose performance is giving cause for concern, Isle of Wight, Portsmouth and South East Hampshire Health Authority and local medical committee, undated
2. Clinical governance and clinical quality assurance, the baseline assessment framework, NHS Executive south east region, 1999
3. Clinical Governance, Audit 1998/1999 & Summary report, District Audit, December 1999

APPENDIX B

Views from patients and relatives/friends

METHODS OF OBTAINING VIEWS

i. The investigation sought to establish the views of people who had experience of services for older people at the Gosport War Memorial Hospital since 1998.

ii. CHI sought to obtain views about the service through a range of methods. People were invited to:

- meet with members of the investigation team
- fill in a short questionnaire
- write to the investigation team
- contact by telephone or email

iii. In November 2001, information was distributed about the CHI investigation at Gosport War Memorial Hospital to stakeholders, voluntary organisations and statutory stakeholders. This information included posters advertising stakeholder events, information leaflets about the investigation, questionnaires and general CHI information leaflets. Press releases were issued in local newspapers and radio stations. The Hampshire Constabulary agreed to forward CHI contact details to families who had previously expressed their concerns to them.

iv. The written information was distributed to a large group of potential stakeholders. In total 36 stakeholders and 59 voluntary organisations will have received the above information. These people included:

- Motor Neurone Disease Association, Alzheimer's Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- Portsmouth and South East Hampshire Community Health Council, Isle of Wight, Portsmouth and South East Hampshire Health Authority, local medical committee, members of parliament, nursing homes, Portsmouth social services and Fareham and Gosport primary care groups

STAKEHOLDER RESPONSES

i. CHI received the following responses from patients, relatives, carers, friends and voluntary organisations.

Letters	Questionnaires	Telephone interviews	*Stakeholder interviews
7	2	10	17

(*stakeholders were counted according to the number of attendees and not based on number of interviews)

ii. A number of people who contacted CHI did so using more than one method. In these cases any other form of submitted evidence, was incorporated as part of the stakeholders contact.

Figure B.1 Concerns about care raised by stakeholders by ward and date

	Dryad	Daedalus	Sultan	GWMH	TOTAL
1998		8		2	10
1999	1	5			6
2000		3	3	1	7
2001		1		1	2
GWMH				2	2
TOTAL	1	17	3	6	27

GWMH – Gosport War Memorial Hospital

ANALYSIS OF VIEWS RECEIVED

i. During the CHI investigation stakeholder views highlighted both positive and less positive experiences of patient care.

Positive experiences

ii. CHI received nine letters from stakeholders commenting on the satisfaction of the care that the patients received and highlighting the excellent level of care and kindness demonstrated by the staff. This was also supported by 400 letters of thanks and donations received by the Gosport War Memorial Hospital. The most frequently recurring positive comments from stakeholders were about staff attitude (five responses) and the environment (five responses). Other positive feedback was received about access to services, transfer, prescribing, end of life arrangements, communication and complaints.

iii. The overall analysis of the stakeholder comments indicated that staff attitude and the environment were most highly commended. Examples of staff attitude included comments such as, "one lovely nurse on Dryad went to say hello to every patient even before she got her coat off" and "as a whole the ward was lovely and there was no complaints against the staff". The environment was described as being tidy and clean with good decor. Another comment recognised the ward's attention to maintaining patient dignity with curtains been drawn reducing attention to the patient. One stakeholder commented on the positive experience they had when dealing with the trust concerning a complaint they had made.

Less positive experiences

iv. A number of less positive experiences of patients/friends and relatives were shared with CHI by stakeholders. The following table outlines the most frequently recurring negative comments that corresponded with CHI's terms of reference.

Figure B.2 Less positive views of patient and relative/friend experiences

View	Frequency of responses
Communication with relatives/carers/friends	14
Patient transfer	10
Nutrition and fluids	11
Prescription of medicines	9
Continence management, catheritisation	8
Staff attitude	8
End of life communication with:	
patients	4
relatives/carers/friends	6
Humanity of care ie access to buzzer, clothing	8

v. Patient transfer. Contacts commented on the state of the patient's health before and during the transfer. Other stakeholders mentioned the time that it took to transfer the patient and also highlighted the inappropriate method of transporting the patient.

vi. Nutrition and fluids. Stakeholders highlighted a lack of help in feeding patients. They commented on how dehydrated the patients appeared and the lack of positive communication between the relative/carer and the staff to overcome the relative/carer's concern about the level of nutrition and fluids.

vii. Humanity of care.

- incontinence management – stakeholders felt that there was limited help with patients that needed to use the toilet
- attitude of staff – stakeholders commented on staff attitude, mentioning the length of time it took for staff to respond. Other comments related to the basic lack of care for patients in their last few days
- provision of bells – stakeholders observed that the bells were often out of the patients reach
- management of clothing – stakeholders commented that the patients were never in their own clothes

viii. Arrangements for the prescription, administration, review and recording of medicines. The majority of concerns were around the prescribing of diamorphine. Others centred on those authorised to prescribe the medication to the patient and how this was communicated to the relatives/carer.

ix. Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations. Interviewees indicated a lack of staff contact with the relatives/carers about the condition of the patient and the patient's care plan. Other interviewees commented on how some of the staff were not approachable. One interviewee referred to the absence of lay terms to describe a patient's condition, making it difficult to understand the patient's status of health.

x. Arrangements to support patients and their relatives and carers towards the end of the patient's life. Stakeholders mainly thought that there was a lack of communication from the staff after their relative had died.

xi. Three of the contacts had made complaints to the trust through the NHS complaints procedure. All were dissatisfied about the trust response.

APPENDIX C

Portsmouth Healthcare NHS Trust staff and non executive directors interviewed by CHI

- Baldacchino, L, Health Care Support Worker
- Banks, Dr V, Lead Consultant
- Barker, D, Staff Nurse
- Barker, M, Enrolled Nurse
- Barrett, L, Staff Nurse
- Beed, P, Clinical Manager
- Brind, S, Occupational Therapist
- Cameron, F, General Manager
- Carroll, P, Occupational Therapist
- Clasby, J, Senior Nurse
- Crane, R, Senior Dietician
- Day, G, Senior Staff Nurse
- Douglas, T, Staff Nurse
- Dunleavy, J, Staff Nurse
- Dunleavy, S, Physiotherapist
- Goode, P, Health Care Support Worker
- Hair, Revd J, Chaplain
- Hallman, S, Senior Staff Nurse (until 11 September 2000)
- Hamblin, G, Senior Staff Nurse
- Haste, A, Clinical Manager
- Hooper, B, Project Director
- Humphrey, L, Quality Manager
- Hunt, D, Staff Nurse (until 6 January 2002)
- Jarrett, Dr D, Lead Consultant
- Joice, C, Staff Nurse (until 4 October 1999)
- Jones, J, Corporate Risk Advisor
- Jones, T, Ward Clerk
- King, P, Personnel Director
- King, S, Clinical Risk Advisor
- Landy, S, Senior Staff Nurse
- Langdale, H, Health Care Support Worker
- Law, D, Patient Affairs Manager

- Lee, D, Complaints Convenor & Non Executive Director
- Lock, J, Sister (retired 1999)
- Loney, M, Porter
- Lord, Dr A, Lead Consultant
- Mann, K, Senior Staff Nurse
- Melrose, B, Project Manager – Complaints
- Millett, M, Chief Executive (until 31 March 2002)
- Monk, A, Chairman
- Nelson, S, Staff Nurse
- Neville, J, Staff Nurse (until 1 January 2001)
- O'Dell, J, Practice Development Facilitator
- Parvin, J, Senior Personnel Manager
- Peach, J, Service Manager
- Peagram, L, Physiotherapy Assistant
- Pease, Y, Staff Nurse
- Phillips, C, Speech & Language Therapist
- Piper, I, Operational Director
- Qureshi, Dr L, Consultant
- Ravindrance, Dr A, Consultant
- Reid, Dr I, Medical Director
- Robinson, B, Deputy General Manager
- Scammel, T, Senior Nurse Coordinator
- Taylor, J, Senior Nurse
- Thomas, Dr E, Nursing Director
- Thorpe, M, Health Care Support Worker
- Tubbitt, A, Senior Staff Nurse
- Walker, F, Senior Staff Nurse
- Wells, P, District Nurse
- Wigfall, M, Enrolled Nurse
- Wilkins, P, Senior Staff Nurse
- Williams, J, Nurse Consultant
- Wilson, A, Senior Staff Nurse
- Wood, A, Finance Director
- Woods, L, Staff Nurse
- Yikona, Dr J, Staff Grade Physician

CHI is grateful to Caroline Harrington for scheduling interviews.

APPENDIX D

Meetings or telephone interviews with external agencies with an involvement in elderly care at Gosport War Memorial Hospital

- **Portsmouth Hospitals NHS Trust**

  Jill Angus, Clinical Discharge Coordinator

  Wendy Peckham, Discharge Planner for Medicine

  Clare Bownass, Ward Sister

  Sonia Baryschpolec, Staff Nurse

  Sam Page, Bed Manager, Royal Haslar Hospital

  Sally Clark, Patient Transport Manager

  Julie Sprack, Senior Nurse

  Jeff Watling, Chief Pharmacist

  Vanessa Lawrence, Pharmacist

- **Hampshire Ambulance Service NHS Trust**

  Alan Lyford, Patient Transport Service Manager

- **Isle of Wight, Portsmouth & South East Hampshire Health Authority**

  Penny Humphris, Chief Executive

  Dr Peter Old, Director of Public Health

  Nicky Pendleton, Progamme Lead for Elderly Care Services

- **NHS Executive south east regional office**

  Dr Mike Gill, Regional Director of Public Health

  Dr David Percy, Director of Education and Training

  Harriet Boereboom, Performance Manager

- **Portsmouth and South East Hampshire Community Health Council**

  Joyce Knight, Chairman

  Christine Wilkes, Vice Chair

  Margaret Lovell, Chief Officer

- **Hampshire Constabulary**

  Detective Superintendent John James

- Portsmouth Social Services

  Sarah Mitchell, Assistant Director (Older People)

  Helen Loten, Commissioning and Development Manager

- Hampshire Social Services

  Tony Warns, Service Manager for Adults

- Alverstoke House Nursing and Residential Care Home

  Sister Rose Cook, Manager

- Glen Heathers Nursing and Residential Care Home

  John Perkins, Manager

Other

- League of Friends

  Mary Tyrell, Chair

  Geoff Rushton, Former Treasurer

- Motor Neurone Disease Association

  Mrs Fitzpatrick

- Members of Parliament

  Peter Viggers, MP for Gosport

  Sydney Rapson, MP for Portsmouth North

- Primary Care Groups

  John Kirtley, Chief Executive, Fareham and Gosport Primary Care Groups

  Dr Pennells, Chairperson, Gosport Primary Care Groups

- Portsmouth Local Medical Committee

  Dr Stephen McKenning, Chairman

- Gosport War Memorial Hospital medical committee

  Dr Warner, Chairman

- Local representative for the Royal College of Nursing

  Betty Woodland, Steward

  Steve Barnes, RCN Officer

- **Local representative for Unison**

  Patrick Carroll, Branch Chair

- **Local general practitioners**

  Dr J Barton, Knapman Practice

  Dr P Beasley, Knapman Practice

  Dr S Brook, Knapman Practice

APPENDIX E

Medical case note review team: terms of reference and membership

Terms of reference for the medical notes review group to support the CHI investigation at Gosport War Memorial Hospital

PURPOSE

The group has been established to review the clinical notes of a random selection of recently deceased older patients at the Gosport War Memorial Hospital in order to inform the CHI investigation. With reference to CHI's investigation terms of reference and the expert witness reports prepared for the police by Dr Munday and Professor Ford, this review will address the following:

(i) the prescription, administration, review and recording of drugs

(ii) the use and application of the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs

(iii) the quality of nursing care towards the end of life

(iv) the recorded cause of death

METHOD

The group will review 15 anonymised clinical notes supplied by the trust, followed by a one day meeting at CHI in order to produce a written report to inform the CHI investigation. The group will reach its conclusions by 31 March 2002 at the latest.

MEMBERSHIP

- Dr Tony Luxton, Geriatrician
  Cambridge City PCT
  (CHI doctor team member and chair of the group)
- Maureen Morgan, Independent Management Consultant
  (CHI nurse member)
- Professor Gary Ford, Professor of Pharmacology of Old Age
  University of Newcastle and Freeman Hospital
- Dr Keith Munday, Consultant Geriatrician
  Frimley Park Hospital
- Annette Goulden, Deputy Director of Nursing
  NHS Trent regional office and formerly
  Department of Health Nursing Officer for elderly care

FINDINGS OF GROUP

The findings of the group will be shared with:

(i) the CHI Gosport investigation team

(ii) CHI's Nurse Director and Medical Director and other CHI staff as appropriate

(iii) the trust

(iv) relatives of the deceased (facilitated by the trust) if requested, on an individual basis

The final report of the group will be subject to the rules of disclosure applying to CHI investigation reports.

APPENDIX F

Report of the Gosport investigation medical notes review group

PURPOSE

CHI undertook a review of the anonymised medical notes of a random selection of 15 patients who had died between 1 August 2001 and 31 January 2002 on Daedalus, Dryad or Sultan wards at Gosport War Memorial Hospital.

CHI's intention for this piece of work was to determine whether the policies and systems put in place by the Portsmouth Healthcare NHS Trust since the events of 1998, to address prescribing practices are being implemented and are impacting on the quality of care patients are now receiving. CHI's review also considered the nursing notes for each patient and looked at the quality of nursing care as documented in the notes. Finally, the review considered whether the cause of death recorded in the notes was appropriate.

METHODOLOGY

The group received 15 sets of anonymised medical notes from the trust, which related to the last admission of 15 patients. Five patients were randomly selected from each of the following wards: Daedalus, Dryad and Sultan. A total of 49 patients had died whilst on these wards during the sample timeframe.

FINDINGS

(i) *Use of medicines*

Prescription

The group considered that the volume and combination of medicines used was appropriate for this group of patients and was in line with accepted good practice and British National Formulary guidelines. Single prescription, PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the trust's 'analgesic ladder' to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggest that patients had been prescribed large amounts of pain relief, such as diamorphine on admission where this was not necessary. Co-codamol had been prescribed in a number of cases as an initial analgesic, with progression to alternative medicines as and when more pain relief was needed. The use of the analgesic ladder was less evident in Sultan ward.

However, in two cases, the group saw evidence of unacceptable breakthrough pain, and six hourly rather than four hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of co-codamol and fentanyl, which was not thought by the group to be the most effective combination of medicines.

Administration

Syringe drivers had been used to deliver medication to six of the patients reviewed. Appropriate use of syringe drivers as a method of medicine administration was observed, with documented discussions with families before use.

Appropriate administration of medicines by nursing staff was evident. Prescriptions issued over the telephone by GPs on Sultan ward were appropriately completed in accordance with trust policy.

Review and recording of medicines

Evidence of consistent review of medication was seen, with evidence to suggest that patients and relatives were involved in helping to determine levels of pain. Nursing staff had appropriately administered medicines in line with medical staff prescriptions. Prescription sheets had been completed adequately on all three wards. Generally, record keeping around prescribing was clear and consistent, though this was not as clear on Sultan ward.

Based on the medical notes reviewed, the group agreed that the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs were being adhered to.

(ii) *Quality of nursing care towards the end of life*

The team found a consistently reasonable standard of care given to all patients they reviewed. The quality of nursing notes was generally adequate, although not always of consistent quality. There was some evidence to suggest a task oriented approach to care with an over emphasis on the completion of paperwork. This left an impression of a sometimes disjointed rather than integrated individual holistic assessment of the patient. The team saw some very good, detailed care plans and as well as a number of incidences where no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphagia had been delayed over a weekend because of the lack of availability of suitably trained nursing staff. Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, the trust's policies regarding fluid and nutrition were generally being adhered to. Though based on the nursing notes, a number of patients had only been weighed once, on admission.

There was evidence of therapy input, but this had not always been incorporated into care plans and did not always appear comprehensive. There was some concern that despite patients being assessed as at risk of pressure sores, it was not clear how this had been managed for some patients.

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. Do not attempt resuscitation decisions were clearly stated in the medical records.

Recorded cause of death

The group found no cause for concerns regarding any of the stated causes of death.

GENERAL COMMENTS

Admission criteria

The team considered that the admission criteria for Daedalus and Dryad wards was being adhered to. However there were examples of patients admitted to Sultan ward who were more dependent than the admission criteria stipulates. There is also an issue regarding patients who initially meet the admission criteria for Sultan ward who then develop complications and become more acutely sick.

Elderly medicine consultant input and access to specialist advice

Patients on Daedalus and Dryad wards received regular, documented review by consultant staff. There was clear evidence of specialist input, from mental health physicians, therapists and medical staff from the acute sector.

Out of hours cover

There was little evidence of out of hours input into the care of patients reviewed by CHI, though the team formed the view that this had been appropriate and would indicate that the general management of patients during regular hours was therefore of a good standard.

APPENDIX G

An explanation of the dissolution of services into the new primary care trusts

Figure G.1 Arrangements for hosting clinical services

Department	Portsmouth City PCT	East Hampshire PCT	Fareham & Gosport PCT	West Hampshire NHS Trust
Elderly medicine		●		
Elderly mental health		●		
Community paediatrics	●			
Adult mental health services	● For Portsmouth patients			● For Hampshire patients
Learning disability services			●	
Substance misuse	●			
Clinical pyschology	●			
Primary care counselling				●
Specialist family planning	●			
Palliative care		●		

(Source: *Local health, local decisions*, consultation document, September 2001, NHS Executive South East Regional Office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

APPENDIX H

Patient throughput data 1997/1998 – 2000/2001

Figure H.1 Throughput data 1997/1998 – 2000/2001

Financial year	Ward	Finished consultant episodes
1997/1998	Daedalus	97
1997/1998	Dryad	72
1997/1998	Sultan	287
	Total	456
1998/1999	Daedalus	121
1998/1999	Dryad	76
1998/1999	Sultan	306
	Total	503
1999/2000	Daedalus	110
1999/2000	Dryad	131
1999/2000	Sultan	402
	Total	643
2000/2001	Daedalus	113
2000/2001	Dryad	86
2000/2001	Sultan	380
	Total	579

(Source: 1997/1998 – trust ward based discharge data, 1998/1999, 1999/2000 and 2000/2001 – trust patient administration system (PAS) data).

APPENDIX I

Breakdown of medication in Dryad, Sultan and Daedalus wards at Gosport War Memorial Hospital

Figure I.1 Summary of medicine usage 1997/1998–2000/2001 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total			6	10	0	19
Diamorphine via syringe driver	Sultan	5mg	1	0	10	0	0
	Total			0	10	0	0
Diamorphine injection	Daedalus	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	67	36	24	35
	Total			128	127	107	74
Diamorphine via syringe driver	Dryad	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total			0	37	0	0
Diamorphine injection	Daedalus	30mg	5	16	27	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	43	14	31
	Total			117	121	69	42
Diamorphine via syringe driver	Dryad	30mg	1	0	5	0	0
	Total			0	5	0	0
Diamorphine injection	Daedalus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total			34	51	3	33

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	500mg	5	0	1	0	0
	Dryad	500mg	5	0	2	0	0
	Sultan	500mg	5	1	1	0	4
	Total			1	4	0	4
Haloperidol injection	Daedalus	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
	Sultan	5mg/5ml	10	43	15	6	0
	Total			44	19	6	0
Haloperidol injection	Daedalus	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
	Sultan	5mg/5ml	5	0	0	0	16
	Total			0	0	0	21
Midazolam	Daedalus	10mg/2ml	10	37	51	39	17
	Dryad	10mg/2ml	10	75	108	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total			133	168	116	47

(Source: Portsmouth Healthcare NHS Trust)

Dose: a single measured quantity of medicine

Pack: a collection of single doses, the packaging in which medicines are dispatched from the pharmacy

APPENDIX J

Glossary

accountability responsibility, in the sense of being called to account for something.

action plan an agreed plan of action and timetable that makes improvements to services.

acute care/ trust/hospital short term (as opposed to chronic, which means long term).
Acute care refers to medical and surgical treatment involving doctors and other medical staff in a hospital setting.
Acute hospital refers to a hospital that provides surgery, investigations, operations, serious and other treatments, usually in a hospital setting.

allied health professionals professionals regulated by the Council for Professions Supplementary to Medicine (new Health Professions Council). This includes professions working in health, social care, education, housing and other sectors. The professions are art therapists, music therapists and drama therapists, prosthetists and orthotists, dieticians, orthoptists, occupational therapists, physiotherapists, biomedical scientists, speech and language therapists, radiographers, chiropodists and podiatrists, ambulance workers and clinical scientists. Also called professionals allied to or supplementary to medicine.

analgesia medicines prescribed to reduce pain.

anticipatory prescribing to prescribe a drug or other remedy in advance.

antipsychotics A group of medicines used to treat psychosis (conditions such as schizophrenia) and sometimes used to calm agitation. Examples include haloperidol. Also called major tranquillisers or neuroleptics.

appraisal an assessment or estimate of the worth, value or quality of a person or service or thing.

Association of Chief Police Officers (ACPO) an association whose members hold the rank of Chief Constable, deputy Chief Constable or Assistant Chief Constable or their equivalents. They provide a professional opinion to the Government and appropriate organisations.

audit, clinical audit an examination of records to check their accuracy. Often used to describe an examination of financial accounts in a business.
In clinical audit those involved in providing services assess the quality of care. Results of a process or intervention are assessed, compared with a preexisting standard, changed where necessary, and then reassessed.

Barthel score a validated tool used to measure physical disability.

benzodiazepines a diverse group of medicines used for a range of purposes. Some reduce anxiety, others are used as sleeping tablets. Some, such as *midazolam*, act as strong sedatives and can be accompanied by memory loss whilst the medicine is active.

British National Formulary publication that provides information on the selection and use of medicines for healthcare professionals.

carers people who look after their relatives and friends on an unpaid, voluntary basis often in place of paid care workers.

casemix the variety and range of different types of patients treated by a given health professional or team.

catheter a hollow tube passed into the bladder to remove urine.

catheterisation use of a catheter.

CHI see Commission for Health Improvement.

clinical any treatment provided by a healthcare professional. This will include, doctors, nurses, AHPs etc. Non clinical relates to management, administration, catering, portering etc.

clinical assistant usually GPs, employed and paid by a trust, largely on a part time basis, to provide medical support on hospital wards and other departments.

clinical governance refers to the quality of health care offered within an organisation.
The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." It's about making sure that health services have systems in place to provide patients with high standards of care.

clinical governance review a review of the policies, systems and processes used by an organisation to deliver high quality health care to patients. The review looks at the way these policies work in practice (a health check for a health organisation).

clinical oncologist a doctor who specialises in the treatment of cancer patients, particularly through the use of radiotherapy, but who may also use chemotherapy.

clinical risk management understanding the various levels of risk attached to each form of treatment and systematically taking steps to ensure that the risks are minimised.

clinician/clinical staff a fully trained health professional – doctor, nurse, therapist, technician etc.

clinical negligence scheme for trusts (CNST) an 'insurance' scheme for assessing a trust's arrangements to minimise clinical risk which can offset costs of insurance against claims of negligence. Successfully gaining CNST 'standards' (to level one, two, three) reduces the premium that the trust must pay.

Commission for Health Improvement (CHI) independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.

co-codamol a medicine consisting of paracetamol and codeine phosphate, used for the relief of mild to moderate pain.

community care health and social care provided by health care professionals, usually outside hospital and often in the patient's own homes.

community health council (CHC) a statutory body sometimes referred to as the patients' friend. CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.

consultant a fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care. (For training posts in medicine see specialist registrar, senior house officer and preregistration house officer.)

continence management The practice of promoting or sustaning the ability to control urination and defecation.

continuing care a long period of treatment for patients whose recovery will be limited.

defibrillator a piece of equipment which sends an electric current through the heart to restore the heart beat.

diamorphine A medicine used to relieve severe pain.

do not attempt resuscitation (DNAR) or do not resuscitate (DNR) an instruction, which says that if a patient's health suddenly deteriorates to near death, no special measures will be taken to revive their heart. This instruction should be agreed between the patient and doctor or if a patient is not conscious, then with their closest relative.

dysphagia difficulty swallowing.

fentanyl a medicine prescribed to patients who require control of existing pain.

finished consultant episode (FCE) a period of continuous consultant treatment under a specific consultant. If a patient is transferred from one consultant to another it will be counted as two FCEs.

formulary a list of preferred medicinal drugs which are routinely available in a hospital or GP surgery.

General Medical Council (GMC) the professional body for medical doctors which licenses them to practice.

general practitioner (GP) a family doctor, usually patients' first point of contact with the health service.

geriatrician a doctor who specialises in diagnosis and treatment of diseases affecting older people.

haloperidol see antipsychotics.

health authority (HA) statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities.

health community or health economy all organisations with an interest in health in one area including the community health councils, and voluntary and statutory organisations.

Health Service Ombudsman investigates complaints about failures in NHS hospitals or community health services, about care and treatment, and about local NHS family doctor, dental, pharmacy or optical services. Anyone may refer a complaint but normally only if a full investigation through the NHS complaints system has been carried out first.

holistic a method of medical care in which patients are treated as a whole and which takes into account their physical and mental state as well as social background rather than just treating the disease alone.

hyocine a medicine to relieve nausea and sickness.

Improving Working Lives a Department of Health initiative launched in 1999. It includes standards for developing modern employment services, putting in place work/life balance schemes and involving and developing staff.

incident reporting system a system which requires clinical staff to report all matters relating to patient care where there has been a special problem.

independent review stage two of the formal NHS complaints procedure, it consists of a panel, usually three members, who look at the issues surrounding a complaint.

intermediate care a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.

intranet an organisation's own internal internet which is usually private.

investigation – by CHI an in depth examination of an organisation where a serious problem has been identified.

Investors in People a national quality standard which sets a level of good practice for improving an organisation's performance through its people.

lay member a person from outside the NHS who brings an independent voice to CHI's work.

local medical committee (LMC) a group of local GPs, elected by the entire local GP population who meet with the health authority to help plan resources and inform decisions.

locum a temporary practitioner who stands in for the permanent one.

medical the branches of medicine concerned with treatment through careful use of medicines as opposed to (surgical) operations.

medical director the term usually used for a doctor at trust board level (a statutory post) responsible for all issues relating to doctors and medical and surgical issues throughout the trust.

midazolam see benzodiazepines.

multidisciplinary from different professional backgrounds within healthcare (e.g. nurse, consultant, physiotherapist) concerned with the treatment and care of patients.

multidisciplinary meetings meetings involving people from different professional backgrounds.

multiprofessional from different professional backgrounds, within and outside of healthcare (e.g. nurse, consultant, social worker) concerned with the care or welfare of people.

National Service Framework (NSF) guidelines for the health service from the Department of Health on how to manage and treat specific conditions, or specific groups of patients e.g. Coronary Heart Disease, Mental Health, NSF for older people. Their implementation across the NHS is monitored by CHI.

neuroleptic see antipsychotics.

neurology a branch of medicine concerned with medical treatment of disorders of the nervous system.

NHS regional office

NHS trust a self governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.

Nursing and Midwifery Council The Nursing Midwifery Council (NMC) is an organisation set up by Parliament to ensure nurses, midwives and health visitors provide appropriate standards of care to their patients and clients. All qualified nurses, midwives and health visitors are required to be members of the NMC in order to practice.

nursing director the term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing throughout the trust.

occupational therapist a trained professional (an allied health professional) who works with patients to assess and develop daily living skills and social skills.

ombudsman see national health service ombudsman above.

opiates a group of medicines containing or derived from opium, that act to relieve severe pain or induce sleep.

opioid a description applied to medicines that cause similar effects in the body to opiates.

outpatient services provided for patients who do not stay overnight in hospital.

pain management a particular type of treatment that concentrates on managing a patient's pain – rather than seeking to cure their underlying condition – and complements their treatment plan.

palliative a term applied to the treatment of incurable diseases, in which the aim is to mitigate the sufferings of the patient, not to effect a cure.

palliative care care for people with chronic or life threatening conditions from which they will not recover. It concentrates on symptom control and family support to help people have as much independence and quality of life as is possible.

patient administration system (PAS) a networked information system used in NHS trusts to record information and inpatient and outpatient activity.

patient advice and liaison service (PALS) a new service proposed in the July 2000 NHS plan due to be in place by 2002, that will offer patients an avenue to seek advice or complain about their hospital care.

patient centred care a system of care or treatment is organised around the needs of the patient.

patient involvement the amount of participation that a patient (or patients) can have in their care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

primary care family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

PCG Organisations now almost completely replaced by primary care trusts. Set up in 1997, PCGs were new organisations (technically Health Authority committees) that brought together all primary care practices in a particular area. PCGs were led by primary care professionals but with lay and social services representation. PCGs were expected to develop local primary health care services and work to improve the health of their populations. Some PCGs additionally took responsibility for commissioning secondary care services.

PCT Organisations that bring together all primary care practices in an area. PCTs are diverse and complex organisations. Unlike PCGs, which came before them, they are independent NHS bodies with greater responsibilities and

powers. They were set up in response to the Department of Health's *Shifting the Balance of Power* and took over many health authority functions. PCTs are responsible for

- improving the health of their population
- integrating and developing primary care services
- directly providing community health services
- commissioning secondary care services

PCTs are increasingly working with other PCTs, local government partners, the voluntary sector, within clinical networks and with 'shared service organisations' in order to fulfil their roles.

level four PCT brings together commissioning of secondary care services and primary care development with the provision of community health services. They are able to commission and provide services, run community health services, employ the necessary staff, and own property.

PRN (Pro re nata) prescribing medication as and when required.

protocol a policy or strategy which defines appropriate action.

psychiatrist a doctor who specialises in the diagnosis and treatment of mental health problems.

regional office see NHS regional office above.

rehabilitation the treatment of residual illness or disability which includes a whole range of exercise and therapies with the aim of increasing a patient's independence.

resuscitation a range of procedures used when someone has suddenly become seriously ill in a way that threatens their life.

risk assessment an examination of the risks associated with a particular service or procedure.

risk management understanding the various risks involved and systematically taking steps to ensure that the risks are minimized.

Royal College of Nursing (RCN) the world's largest professional union of nurses. Run by nurses, it campaigns on the part of the profession, provides higher education and promotes research, quality and practice development through the RCN institute.

sensory disabilities people who have problems hearing, seeing, smelling or with touch.

specialist a clinician most able to progress a patient's diagnosis and treatment or to refer a patient when appropriate.

speech and language therapist professionally trained person who assists, diagnoses and treats the whole spectrum of acquired or developmental communication disorders.

staff grade a full qualified doctor who is neither a General Practitioner nor a consultant.

staff grade doctors doctors who have completed their training but do not have the qualifications to enable them to progress to consultant level. Also called trust grade doctors.

stakeholders a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation. In the case of hospital trusts, it includes patients, carers, staff, unions, voluntary organisations, community health councils, social services, health authorities, GPs, primary care groups and trusts in England, local health groups in Wales.

statutory/statute refers to legislation passed by Parliament.

strategic health authority organisations that will replace health authorities and some functions of Department of Health regional offices in 2002. Unlike current health authorities, they will not be involved in commissioning services from the NHS. Instead they will performance manage PCTs and NHS trusts and lead strategic developments in the NHS. Full details of the planned changes are in the Department of Health document, Shifting the Balance of Power, July 2001.

strategy a long term plan for success.

subcutaneous beneath the skin.

swallowing assessments the technique to access the ability of the patient to swallow safely.

syringe driver a device to ensure that a syringe releases medicine over a defined length of time into the body.

terminal care care given in the last weeks of life.

terms of reference the rules by which a committee or group does its work.

trust board a group of about 12 people who are responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and directors.

Unison Britain's biggest trade union. Members are people working in the public services.

United Kingdom Central Council (UKCC) on 1 April 2002 the UKCC ceased to exist. Its successor body is The Nursing and Midwifery Council (NMC). Its purpose was to protect the public through establishing and monitoring professional standards.

ward round A regular review of each patient conducted by a consultant, often accompanied by nursing, pharmacy and therapy staff.

Wessex palliative care guidelines local guidance to help GPs, community nurses and hospital staff as well as specialist palliative care teams. It provides a checklist for management of common problems in palliative care, with some information on medical treatment. It is not a comprehensive textbook.

whistle blowing the act of informing a designated person in an organisation that patients are at risk (in the eyes of the person blowing the whistle). This also includes systems and processes that indirectly affect patient care.

whistle blowing policy a plan of action for a person to inform on someone or to put a stop to something.

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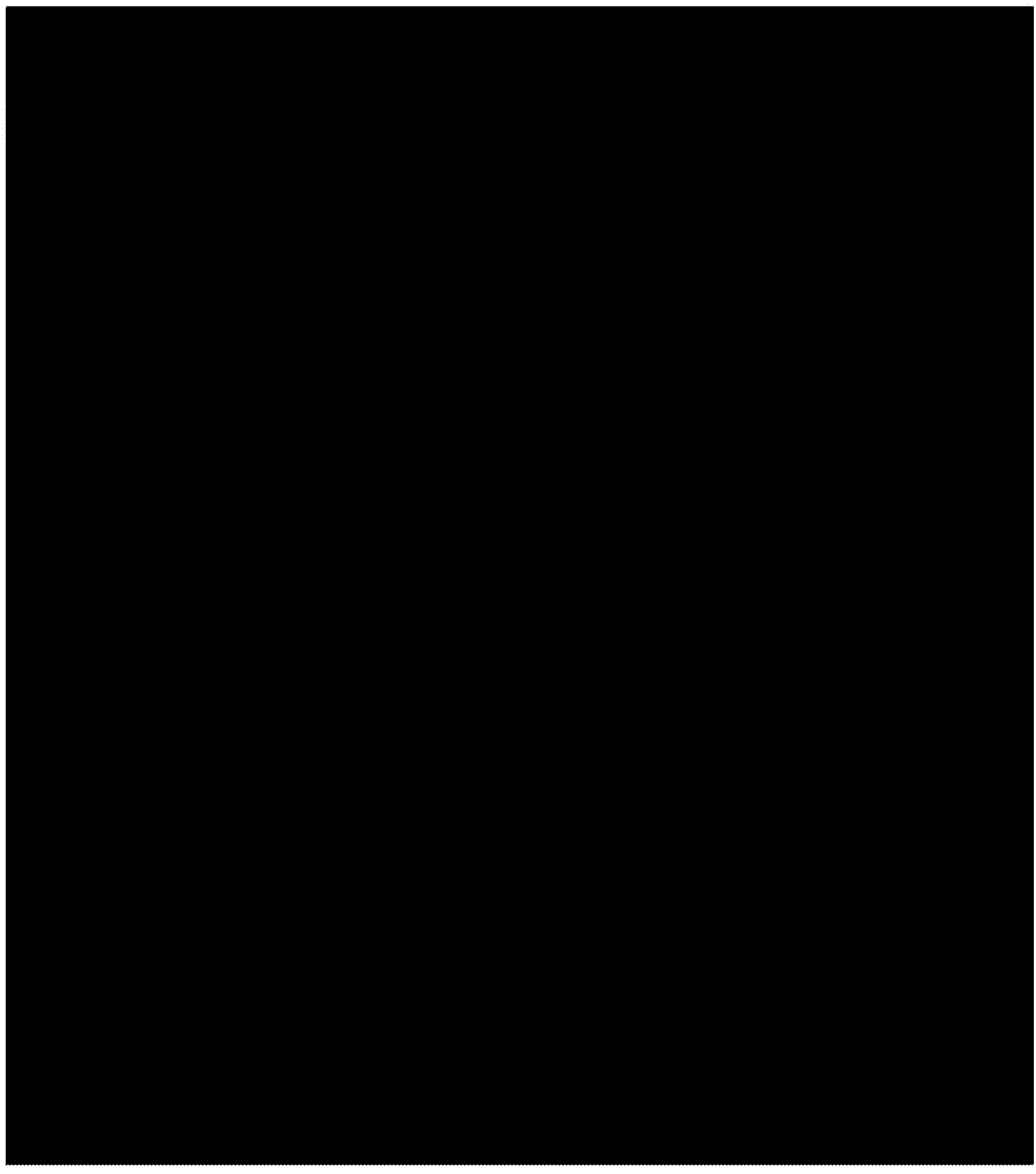


Joe Miles

From: Paul Hylton Code A
Sent: 28 July 2006 12:23
To: Code A
Cc: 'Jones, Peter'
Subject: RE: OP Rochester..Gosport War Memorial Investigation.

Dear Det Supt Williams

Thank you for the update.

I look forward to receiving a further update once you have met with Treasury Counsel.

Paul Hylton

-----Original Message-----
From: Code A
Sent: 28 Jul 2006 12:11
To: Paul Hylton (020 7189 5115)
Cc: Code A;
Code A
Subject: OP Rochester..Gosport War Memorial Investigation.

Dear Paul Hylton(GMC)/ Clare Strickland(NMC) /Jenifer Smith(SHA) David HORSLEY(H.M.Coroner)

Please find attached a family group update letter that I am sending today to relatives of the 10 remaining cases under investigation.

<<Operation ROCHESTER Family Group Update 28/7/2006.>>

All files have now been forwarded to the CPS and I am meeting with Treasury Counsel next week Wednesday the 2nd August to discuss the outcome.

We have also been interviewing (under caution)a consultant Geriatrician Dr Richard Ian REID in respect of 2 cases (of the 10 above) the deaths of Edith SPURGIN and Geoffrey PACKMAN. The final interview with Dr REID is being held on 8th August 2006.. The police investigation into these matters is then essentially complete.

Once the decision in respect of any prosecution is made (in my view not all of these cases meet the standard of evidence required to prosecute criminally and the public interest hurdle remains to be addressed) then we will need to get together to discuss further disclosure to the GMC and NMC.

I spoke with Dr BARTON's legal rep Ian BARKER last week, he confirmed that Dr BARTON was still adhering to the voluntary agreement not to prescribe Opiates and Benzodiazepines.. She has however now taken a senior practice partner position at her surgery..

I will be in touch post 2nd August to discuss the way forward.. It may be appropriate to pull all stakeholders together to talk this through including the local Portsmouth

Coroner Mr David HORSLEY.

Regards..

Dave WILLIAMS Det Supt..
Code A

Joe Miles

From: Paul Hylton Code A
Sent: 07 August 2006 12:37
To: Paul Philip (Code A
Cc: Peter Swain
Subject: RE: Gosport

Paul

I spoke to the Police last week for an update.

There are 10 cases currently with the CPS, a decision is expected within the next fortnight.

Peter and I had a meeting with Eversheds in July as we have a nagging doubt in our minds regarding whether the CPS will prosecute Dr Barton. We have instructed Eversheds to contact the Police to inform them that we plan to resume investigations in respect of the cases they have transferred to us unless they give us good reasons in writing as to why we should not do so.

We are awaiting a response from the Police.

Paul

-----Original Message-----
From: Paul Philip Code A
Sent: 07 Aug 2006 12:27
To: Paul Hylton
Cc: Peter Swain Code A
Subject: Gosport

Paul,

Where are we with the Gosport case and have we written to the police for an update recently?

Paul

Sent from my BlackBerry Wireless Handheld

[redacted]
Professiona
l Privilege
LPP

[redacted]

[redacted]

[redacted] [redacted] [redacted]

Privilege LPP

[redacted]2007

Operation ROCHESTER.

Case-file submission dates.

Elsie DEVINE - 24.12.2004.

Elsie LAVENDER – 18.05.2005.

Leslie PITTOCK – 18.05.2005.

Ruby LAKE – 17.11.2005.

Arthur CUNNINGHAM – 17.11.2005.

Robert WILSON – 14.06.2006.

Enid SPURGIN – 14.06.2006.

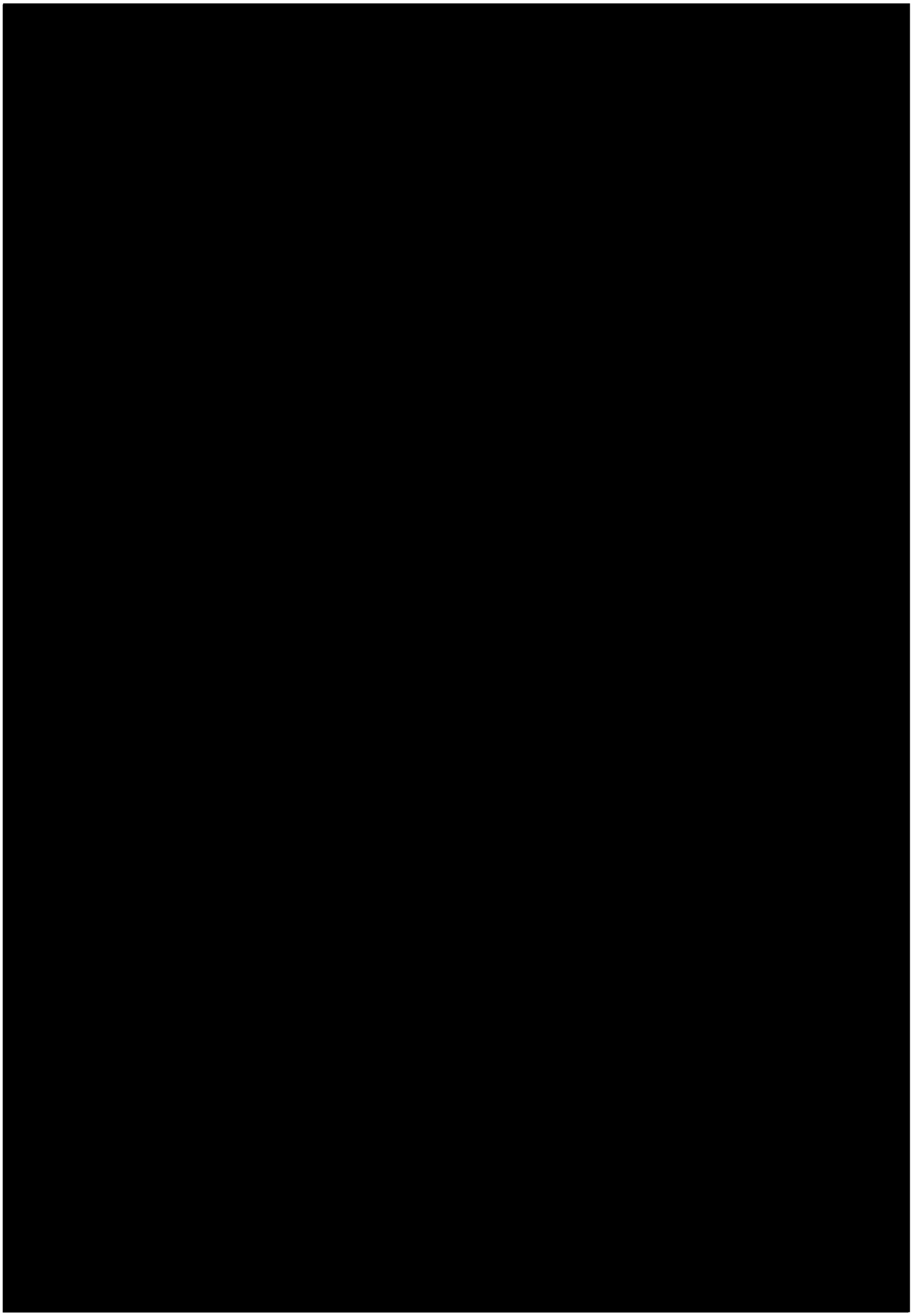
Geoffrey PACKMAN – 27.06.2006.

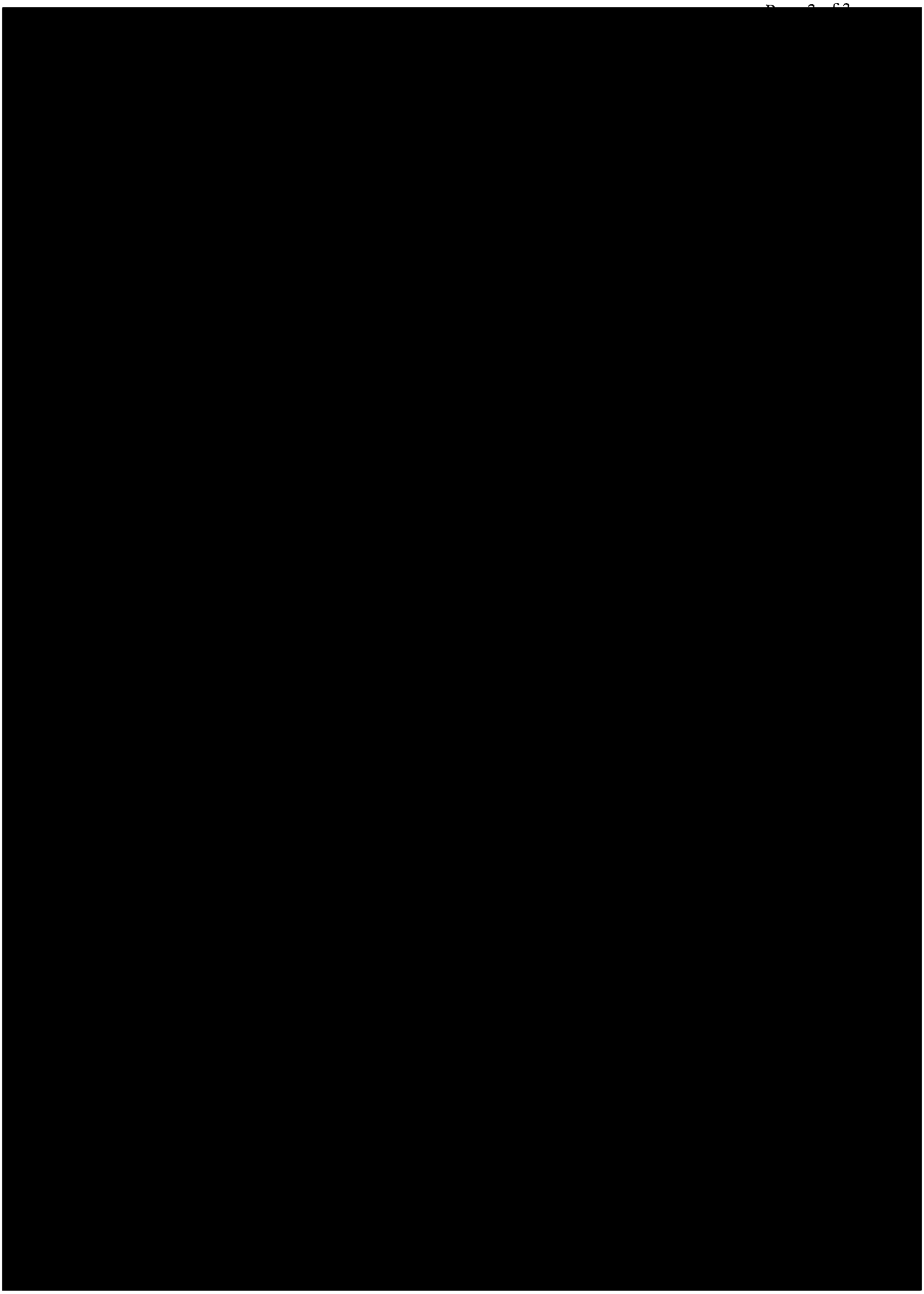
Helena SERVICE – 27.07.2006.

Sheila GREGORY – 27.07.2006.

+ Generic witness statements/case-file exhibits/medical note translations/glossary of terms.

DW.
Det Supt
01.08.2006.





Joe Miles

From: Code A
Sent: 20 December 2006 16:59
To:
Cc: Code A
Subject: FW: letter to Det Supt Williams

Dear Louisa..

I have forwarded your request to Det Insp Dave GROCOTT who will deal with the disclosure issues..
Please find attached a summary of the 10 cases.

Regards

David WILLIAMS
Detective Superintendent.

From: Morris, Luisa [mailto: Code A
Sent: 20 December 2006 16:21
To: Williams, David
Subject: letter to Det Supt Williams

**** Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email. ****

Please see attached letter following our meeting yesterday.

Yours sincerely

LUISA MORRIS
FOR EVERSHEDS LLP

****** Eversheds is supporting both Unicef and Breast Cancer Campaign as an alternative to sending Christmas cards and E-cards. We wish all our clients and contacts a Happy Christmas and prosperous New Year. ******

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********** [http://www.eversheds.com/] **********

Det Supt Dave Williams
Hampshire Constabulary

Date 20 December 2006
Your ref
Our ref 4/LXM

Code A

Dear Det Supt Williams

Operation Rochester

Further to the stakeholder meeting of yesterday, as we discussed we are keen to progress the GMC's investigation swiftly. Therefore, I would be grateful if you could provide, or make available to us to inspect at your offices:

1) the summary document that we discussed yesterday outlining the evidence in respect of the 10 cases that were identified for the CPS to consider, namely Elsie Devine, Elsie Lavender, Leslie Pittock, Ruby Lake, Arthur Cunningham, Robert Wilson, Enid Spurgin, Geoffrey Packman, Helene Service, and Sheila Gregory.

2) all witness statements, expert evidence, transcripts of police interviews and medical records relevant to the investigation of the above 10 cases together with any evidence that remains in your possession relating to Eva Page, Alice Wilkie and Gladys Richards.

3) an index of all evidence obtained to date.

I understand that you are awaiting consent from family members in respect of some of the documentation, but request that you provide such documentation as is available as soon as possible, even if that means providing the information in a piecemeal fashion. This will then enable the GMC to make an early assessment of the individual cases.

I look forward to hearing from you.

Yours sincerely

Luisa Morris
FOR EVERSHEDS LLP

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Cardiff
CF10 5BT

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Fax 0845 498 7333
Int +44 20 7497 9797
DX 33016 Cardiff
www.eversheds.com

Joe Miles

From: Code A
Sent: 20 December 2006 17:39
To:
Cc: Code A
Subject: FW: letter to Det Supt Williams

Luisa.
4 summary documents attached..DW.

From: Morris, Luisa Code A
Sent: 20 December 2006 17:29
To: Williams, David
Subject: RE: letter to Det Supt Williams

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Thank you.The note states that there are 14 Cat 3 cases, but in 4 of those cases death was from natural causes although there were negligence issues to be explored. Please could you confirm the identities of those 4.

Kind regards

Luisa

From: Code A [mailto: Code A
Sent: 20 December 2006 17:11
To: Morris, Luisa
Cc: Code A
Subject: FW: letter to Det Supt Williams

Apologies..
DW.

From: Morris, Luisa [mailto Code A
Sent: 20 December 2006 17:06
To: Williams, David
Subject: RE: letter to Det Supt Williams

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Thank you, unfortunately the summary was not attached, please could you resend it?
Kind Regards
Luisa

From: Code A [mailto: Code A

Sent: 20 December 2006 16:59
To: Morris, Luisa
Cc: Code A
Subject: FW: letter to Det Supt Williams

Dear Louisa..
I have forwarded your request to Det Insp Dave GROCOTT who will deal with the disclosure issues..
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Regards
David WILLIAMS
Detective Superintendent.

From: Morris, Luisa [mailt Code A
Sent: 20 December 2006 16:21
To: Williams, David
Subject: letter to Det Supt Williams

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Yours sincerely
LUISA MORRIS
FOR EVERSHEDS LLP

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Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Thomas JARMAN

Mr Jarman was a widower living alone in Fareham. He had a son and daughter in law Alec and Marjorie who were his main carers. He had a home help who would visit once a week.

He was in good health until early 1999 during which he slowly declined over the course of the year probably due to the onset of leukaemia. In June 1999 Mr Jarman moved to The Red House Residential Home when according to his son and daughter in law he was unable to cope at home and had been diagnosed with Hairy cell leukaemia in May he also suffered from Alzheimer's disease.

Mr Jarman was admitted to the Queen Alexander Hospital and then transferred to Gosport War Memorial Hospital on 27th October 1999 with bronchopneumonia, septicaemia and a stroke from which he had made no real physical, functional or mental recovery for continuing care and rehabilitation.

He deteriorated over the four weeks of his admission and died on 10th November 1999.

Cause of death was recorded as bronchopneumonia and hairy cell leukaemia.

When admitted to Daedalus Ward there existed a summary in the notes of his recent problem but no clinical examination was recorded. The notes state:- "in view of poor prognosis, not for 999. I am happy for any nurse to verify his death. Mainly for TLC."

Mr Jarman was distressed and unwell on 7th November, as a result a decision was made (not clear if this was purely a nursing decision or whether there was medical involvement) to prescribe the 'as required Oramorph'

When this had little effect a decision was made to start Midazolam alone in a syringe driver.

Finally Diamorphine was added to the syringe driver at 0010 on the 8th November 1999. Mr JARMAN received a medical review during that day and was found to be frail but comfortable though further deteriorating.

On 9th November an increased dose of Diamorphine was required, this being justified in the nursing cardex as he does not appear comfortable (despite receiving 30 mgs of Diamorphine currently in the syringe driver) and with increased agitation.

It would appear at this stage that 60 mgs of Diamorphine was started in the syringe driver together with the Hyoscine and 2 mgs of Haloperidol. Later Mr JARMAN is recorded as being much more comfortable.

On 10th November a new prescription of Diamorphine, Hyoscine and Haloperidol was written up regularly and 100 mgs placed in the syringe driver at 09.45hrs.

Thomas JARMAN died at 14.50hrs the same day. It is not clear why this new prescription was written up, or why a dose of 100 mgs was chosen, nor is it clear whether this was chosen by the medical or nursing staff.

This case was brought to the attention of Operation ROCHESTER in 2002 by Mr Alec JARMAN.

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Mr JARMAN was potentially negligent that he died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Mr JARMAN.

The expert concluded that Mr Jarman was an extremely frail and elderly gentleman when he entered the Gosport War Memorial Hospital and was not going to recover from his various problems. It was inevitable that he was going to deteriorate and die in hospital.

Recording of the medical notes seemed very poor and the justification for writing up various medications was not made clear in the medical notes.

The Geriatrician thought it reasonable that he received doses of Oramorph on 7th November when he was distressed and deteriorating. It was also appropriate that he was started on a syringe driver including 20 mgs of Diamorphine on 8th November as well as the Haloperidol and Midazolam to help his agitation.

He commented that Midazolam is widely used subcutaneously in doses from 5 – 80 mgs in 24 hours and is particularly used in terminal restlessness. The

dose of Midazolam used was 20 mgs per 24 hours which was within current guidance; although many believe that elderly patients may need a dose of 5 – 20 mgs per 24 hours.

The dose of Diamorphine was raised to 30 mgs on 9th November and then apparently doubled up to 60 mgs because he showed continual stress and agitation. As Mr Jarman settled following this medication change the geriatrician concluded that it was a reasonable change in dosage.

Whilst there was nothing recorded as to why Mr JARMAN's Diamorphine was re-written on 10th November, or any information about the decision to give him a 100 mgs from 09.45 on 10th November, it was the experts view that this was probably an unnecessary step up in dosage as there was nothing to suggest he was not still settled on the 60 mgs in 24 hours dose. It was possible that this may have had the effect of very slightly shortening Mr Jarman's life by no more than a few hours.

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Edwin CARTER

Mr Carter was a frail 92 year old widower with a son and lived in a rest home in Southsea. He was a retired civil servant for the Department of Health. He had multiple medical problems over a number of years. His health started to more rapidly decline and enter a final phase from July 1993. A probable (and likely) diagnosis of carcinoma of stomach was made and he received palliative care in hospital until the time of his death on 24th December 1993.

Cause of death was recorded as cancer of the stomach and bronchopneumonia.

On 20th July, 1993 Mr Carter had an emergency admission following a domiciliary visit. The GP had referred on the 7th July because he was deteriorating generally with episodic vomiting with altered blood. The domiciliary visit letter documents vomiting and weight loss, feeling fed up and being depressed but he was mobilising indoors. He was discharged on 30th July where as he had not been noted to vomit on the ward a Barium Meal had been undertaken. The report of the Barium Meal documents an abnormality in the gastric fundus with mucosal irregularity. It was difficult to undertake the procedure because of patient immobility. A gastroscopy to take biopsies is recommended. It was also noted on the abdominal x-ray, that he had abnormal trabecula pattern in the right hemi-pelvis suggestive of Paget's disease. The report of the Barium Meal is suggestive but not diagnostic of gastric cancer.

A letter from the GP, August 1993 notes that Mr Carter is very frail, that there was no question that he could have a gastric operation should cancer be confirmed, that actually undertaking further investigations would be difficult and unpleasant and he suggests that Mr Carter should be just managed symptomatically. The consultant Dr Lord agrees and offers palliative care, if and when, it is needed.

On 25th October he is admitted as an emergency to St Mary's General Hospital with vomiting and severe back pain. The GP states in his letter that he had already started regular Diamorphine. However it is not clear from the GP's letter when it was started and how much the patient was currently on. The GP believes that the patient now needs a syringe driver.

Subsequently Mr Carter is transferred to John Pounds Ward for pain control and is recorded as being on Diamorphine pump.

On the 2nd November he is noted to have his pain controlled, however he is now completely dependent with a Barthel of 1. His notes state that his son is aware of the prognosis and agrees to Palliative Care. He is switched to oral morphine for pain control.

On 5th November his family agree to long term care at Gosport War Memorial and it is recorded his pain is well controlled by the oral morphine slow release. He is then admitted on 8th November to Gosport War Memorial for long stay care. He is in no pain and does not want to be examined.

The nursing and medical notes then record between 8th November and 20th December, apart from bouts of nausea, retching, and occasional pyrexia, his pain seems mostly controlled but he is clearly, slowly physically deteriorating. On 20th December it is noted that he was deteriorating further and that sub-cut Diamorphine might be needed.

On 23rd December he is noted to be rapidly deteriorating and that sub-cut analgesia had been commenced the day before (80mgs diamorphine). The family were aware and happy with the management. On 24th December he is recorded as having died peacefully at 12.05 hours.

This case was brought to the attention of Operation ROCHESTER in November 2002 by his son Edwin CARTER (Jr).

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Mr CARTER was potentially negligent that he died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Mr CARTER.

The expert concluded that Mr Edwin Carter was a frail 92 year old gentleman who had had multiple medical problems over a number of years. His health started to more rapidly decline and enter a final phase in July 1993. A probable (and in my view likely) diagnosis of carcinoma of stomach was made and he received palliative care in hospital until the time of his death on 24th December 1993.

The dose of Diamorphine and Midazolam started in the syringe driver on 22nd December might be considered to have been excessive, however I believe

that this made a negligible contribution to the death of Edwin Carter.

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Clifford HOUGHTON

Mr Houghton lived with his wife Gladys in a bungalow in Gosport. They had a daughter Pamela. They lived independently with no outside help. Mr Houghton had poor mobility and had been admitted several times to Gosport War Memorial Hospital for respite care to give his wife a break after suffering a stroke in 1991.

Following a further event (stroke) and decline at the end of January 2004, he is readmitted to the Gosport War Memorial Hospital where he deteriorates and dies over 6 days.

Cause of death was recorded as cerebrovascular accident and senile dementia.

On 31st January 1994 he was readmitted as an emergency and the history was that he had a Transient Ischemic Attack (Mini stroke) on the Friday lasting 20 minutes and since then he had been sleeping excessively.

On 3rd February the medical notes record that his overall condition has deteriorated and he was short of breath and restless, he was not feeding or drinking. The notes suggested that he might have had a further CVA (stroke) but no examination is recorded. No plan is made apart from a chat with the wife. The nursing cardex had noted that he was very variable in condition on 2nd February and very drowsy at times. The nursing notes also record that his condition deteriorated on 3rd February with breathlessness and some distress and he had been seen by Dr Barton and was for a syringe driver "if and when needed". The medical record on 4th February states that he is still unwell and eating and drinking very little.

On 6th February 1994 he is reported to be Cheyne-Stoking (respiratory problem) in the nursing notes and that a syringe driver was started at 7.45. The nursing notes then record the patient was restless, agitated and distressed at 11 am and that a Dr was contacted who arranged for a further one off dose of 5 mgs of Diamorphine to be given. He was then seen by a Dr who arranged for the Diamorphine in the syringe driver to increase to 60 mgs. The medical notes also document these events, that he was very restless on the 40 mg Diamorphine of in 24 hours and that he was given 5 mgs intramuscularly and thereafter Diamorphine 60 mgs in 24 hours was given in the syringe driver. Mr Houghton died at 20.50 on 6th February 1994.

The case was brought to the attention of Operation ROCHESTER in 2002 by Pamela BYRNE via the NHS helpline.

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Mr HOUGHTON was potentially negligent that he died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Mr HOUGHTON.

The expert concluded that Clifford Houghton was a 71 year old gentleman at the time of his death, he had ischaemic heart disease, hypertension then suffered a devastating stroke in 1991, leaving him severely dependent and disabled with a right hemiplegia and severe communication problems. He was cared for at home by his wife but started to decline during the autumn of 1993 and had several admissions to the Gosport War Memorial Hospital, mainly to support his wife. Following a further event (a Transient Ischemic Attack) and decline at the end of January 2004, he is readmitted to the Gosport War Memorial Hospital where he deteriorates and dies over 6 days.

A starting dose of Diamorphine of 10 – 20 mgs in 24 hours in the syringe driver might be more commonly used and many would consider that 40 mgs was an excessive starting dose. Despite this, the doses used fail to manage his symptoms and a further dose of intramuscular sedation is required, given at 11 am. The syringe driver is then restarted with 60 mgs of Diamorphine in 24 hours. This appears to provide adequate symptom control and he dies at 20.10. The evidence in the notes suggests that this was an appropriate therapeutic response to the distressing symptoms being suffered by Mr Houghton

This admission marked the culmination of a progressive decline in his health and it is unlikely that any active or invasive measures would have made a significant difference to the eventual outcome of his care

Although the expert Geriatrication also states that :-The lack of detail in the medical notes, in particular, lack of a recorded clinical assessment at the time of his readmission on 31st January and at the time of a significant deterioration on 3rd February 1994 make it difficult to fully assess the problems suffered by Mr Houghton and the reasons for his final decline and death. However, I

believe that the symptomatic response to his terminal illness was appropriate and that his death was by natural causes.

Operation Rochester.

Medical assessment in respect of Category 3A cases.

Overview Norma WINDSOR.

Mrs Windsor lived with her husband in a house in Gosport. They had just sold this and were hoping to move to a bungalow. They had 3 daughters. Mrs Windsor was deaf in her left ear and wore a hearing aid.
Mrs Windsor was admitted to the EWGH for respite care and gastroenteritis after collapsing. She was transferred to the Gosport War Memorial Hospital on 27th April 2000 for 'build up' and was then transferred to the St Mary's General Hospital where she died on 7th May 2000.

Cause of death was recorded as Cardiogenic Shock, Ischaemic Heart Disease, and Chronic Lymphatic Leukaemia.

Mrs Windsor had a history going back to an operation in 1979 for duodenal ulcer disease. In 1998 she was noted to have an abnormal blood count with lymphadenopathy, was referred for a haematological opinion and an original diagnosis of chronic lymphatic leukaemia was made. In 1998 she had been admitted to hospital acutely with a myocardial infarction, had a positive exercise test and was referred for an angiogram in May 1999. In the meantime she had a bone marrow which confirmed chronic lymphatic leukaemia with lymph node involvement.

In 2000 a cardiologist decided that despite her severe coronary artery disease, she was not fit for surgery because of "a high chance of thrombosis and stroke". In 2000 she is diagnosed to have a post nasal drip.

In early 2000 she was seen in the Gastrointestinal clinic having been referred from the haematologist because of a fall in haemoglobin. It is decided to do further investigations for possible blood loss and an upper GI endoscopy and colonoscopy are booked. Around the same time, she has further haematological investigation and a second bone marrow and she is now thought to have a follicular lymphoma rather than pure chronic lymphatic leukaemia. In March 2000 she is on Prednisolone and Chlorambucil and is noted to be significantly more cheerful. On the 18th April the booked upper and lower gastro intestinal investigations are performed. Her blood pressure is 135/70 prior to the investigations and the two documented blood pressures after are 85/48 and 100/60. She is also noted to be breathless at rest but discharged home. The investigations are reported as showing no significant abnormality, apart from a hiatus hernia. Finally her creatinine on 22nd March was normal at 100 micro mls per litre.

She is admitted into a GP bed by her GP Dr Knapman on 27th April and the medical notes state that she has weakness, exhaustion and depression and a recent bout of diarrhoea and vomiting (514). Her previous past medical history is noted as is her medication of Citalopram, Isosorbide Mononitrate, Aspirin, Nitrolingual Spray, Quinapril and Atenolol. No examination is recorded and the plan is stated to be two weeks to help regain her usual state of health.

On 28th April she is seen by the GP Dr Knapman and her blood pressure is to be monitored. However, there are no medical notes that day and no further medical notes to the 2nd May. The nursing notes on 29th May document a blood pressure of 100/60 and that there had been diarrhoea 3 times that morning. On 30th she continued to have offensive stools, feeling unwell, cold, clammy to the touch, feels hot. She was light headed and standing blood pressure of 90/50, a pulse of 68 and temperature of 36.

On 5th May she is unwell at 10.30 am, cold and clammy, blood pressure unrecordable, weak and thready pulse, her GP is called and comes at 11.50 am. He records that her blood pressure is low at between 80-90/40-50 and asks for her to be transferred to St. Mary's Hospital. However it is not until 17.39 that a bed becomes available.

She arrives at St Mary's Hospital at 18.45 is cold, clammy and dyspnoeic. The on-call medical team is asked to see her urgently at 19.30; the examination finds that she is in extremis, pulse 120, no recordable blood pressure and signs of a large right pleural effusion. A chest x-ray confirms a massive right pleural effusion. The diagnosis is thought to be a combination of septic shock and a large pleural effusion; she is in acute renal failure. She is severely acidotic and passes a large mucus stool, is resuscitated and finally a decision is made for transfer to ITU.

During the course of 6th May she is treated with very intensive medical treatment and at first there is a small improvement in cardiac output. However, she deteriorates later in the day, the family are spoken to at 10.30 and she is then put on a ventilator for respiratory distress.

She finally dies of cardiogenic shock at 02.55 on 7th May.

This case was brought to the attention of Operation Rochester in October 2002 by Mrs Margaret WARD (daughter) via the NHS Helpline.

As a consequence the case was examined by a team of medical experts in geriatrics, palliative care, toxicology, general medicine and nursing. They took the view that whilst the care afforded to Mrs WINDSOR was potentially negligent that she died of natural causes.

This view was independently quality assured and agreed by a legal/ medical lawyer who had access to all of the papers.

Finally an expert Geriatrician was assigned to this case to make a further independent medical and evidential assessment.

He examined in detail the circumstances surrounding the care and treatment of Mrs WINDSOR and concluded that at the time of her death she was a 69 year old lady who suffered from ischaemic heart disease with a proven myocardial infarction, follicular lymphoma and chronic lymphatic leukaemia, problems with her gastrointestinal symptom and finally a massive pleural effusion developing shortly before her death.

Her GP admits her to the Gosport War Memorial Hospital on the 24th April 2000 where a clinical examination is either not undertaken or not recorded. She is recorded as being persistently hypotensive and unwell by the nursing staff over a number of days until her final admission on 5th May to St. Mary's Hospital. At that time she is very seriously ill and despite active and appropriate intensive care dies shortly after. A major problem in assessing this case is the poor documentation in Gosport Hospital, in particular in the medical notes making a retrospective assessment of her progress difficult. The lack of documentation of examination possibly undertaken at the Gosport War Memorial Hospital or accurate information on changes in her clinical status represents poor clinical practice. However, I believe her death was by natural causes.

[redacted]

Mr C Stewart-Farthing

Code A

Date 20 December 2006
Your ref
Our ref 4/LXM

Code A

Dear Mr Stewart-Farthing

General Medical Council - Dr Barton

We are instructed by the General Medical Council in relation to the investigation of the above doctor. The General Medical Council has been notified by Hampshire Constabulary that the Crown Prosecution Service does not intend to prosecute any individual following completion of their investigation of deaths at the Gosport War Memorial Hospital.

It may assist you to explain that the role of the General Medical Council is to investigate allegations of serious professional misconduct, then present those allegations and the evidence in support of the allegations to a Fitness to Practise Panel. The Fitness to Practise Panel considers whether the practitioner is guilty of serious professional misconduct, and if so, what sanction should be imposed upon the practitioner. the sanctions available to the Panel are to issue a reprimand, impose conditions upon the practitioner's practice, to suspend the practitioner, or to erase the practitioner from the medical register.

Whilst the police will have been considering the issue of whether there was any conduct capable of forming a criminal offence, the General Medical Council considers a very different test: whether the conduct falls below the professional standards set out in its Guidance "Good Medical Practice". Good Medical Practices describes the principles and standards of competence, care and conduct expected of the practitioner. Therefore, the fact that the Crown Prosecution Service does not intend to prosecute poses no bar to the General Medical Council's own investigation.

I will now be liaising with Hampshire Constabulary to obtain information from them which will be relevant to our investigation on behalf of the General Medical Council. Upon consideration of the relevant information, I will contact you with further details. In the meantime, I understand that Hampshire Constabulary has requested that you provide your consent to allow them to share the evidence it has gathered with us, including the relevant medical records. I urge you to complete and return the consent form as soon as possible, in order that we can progress the investigation promptly.

Yours sincerely

Luisa Morris
FOR EVERSHEDS LLP

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INVESTOR IN PEOPLE

Date 20 December 2006
Your ref
Our ref 4/LXM

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Yours sincerely

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Date 20 December 2006
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Yours sincerely

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INVESTOR IN PEOPLE

Date	20 December 2006
Your ref	
Our ref	MORRISLX/145634-000025
Page	2

[redacted]

[redacted]

26/04/2007

Det Supt Dave Williams
Hampshire Constabulary

Date 20 December 2006
Your ref
Our ref 4/LXM

Code A

Dear Det Supt Williams

Operation Rochester

Further to the stakeholder meeting of yesterday, as we discussed we are keen to progress the GMC's investigation swiftly. Therefore, I would be grateful if you could provide, or make available to us to inspect at your offices:

1) the summary document that we discussed yesterday outlining the evidence in respect of the 10 cases that were identified for the CPS to consider, namely Elsie Devine, Elsie Lavender, Leslie Pittock, Ruby Lake, Arthur Cunningham, Robert Wilson, Enid Spurgin, Geoffrey Packman, Helene Service, and Sheila Gregory.

2) all witness statements, expert evidence, transcripts of police interviews and medical records relevant to the investigation of the above 10 cases together with any evidence that remains in your possession relating to Eva Page, Alice Wilkie and Gladys Richards.

3) an index of all evidence obtained to date.

I understand that you are awaiting consent from family members in respect of some of the documentation, but request that you provide such documentation as is available as soon as possible, even if that means providing the information in a piecemeal fashion. This will then enable the GMC to make an early assessment of the individual cases.

I look forward to hearing from you.

Yours sincerely

Luisa Morris
FOR EVERSHEDS LLP

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Joe Miles

From: Code A
Sent: 20 December 2006 17:11
To:
Cc: Code A
Subject: FW: letter to Det Supt Williams

Apologies..

DW.

From: Morris, Luisa Code A
Sent: 20 December 2006 17:06
To: Williams, David
Subject: RE: letter to Det Supt Williams

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Thank you, unfortunately the summary was not attached, please could you resend it?

Kind Regards
Luisa

From: Code A [mailto: Code A
Sent: 20 December 2006 16:59
To: Morris, Luisa
Cc: Code A
Subject: FW: letter to Det Supt Williams

Dear Louisa..
I have forwarded your request to Det Insp Dave GROCOTT who will deal with the disclosure issues..
Please find attached a summary of the 10 cases.
Regards
David WILLIAMS
Detective Superintendent.

From: Code A
Sent: 20 December 2006 16:21
To: Williams, David
Subject: letter to Det Supt Williams

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Please see attached letter following our meeting yesterday.
Yours sincerely
LUISA MORRIS
FOR EVERSHEDS LLP

****** Eversheds is supporting both Unicef and Breast Cancer Campaign as an alternative to sending Christmas cards and E-cards. We wish all our clients and contacts a Happy Christmas***

and prosperous New Year. *

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***** Eversheds is supporting both Unicef and Breast Cancer Campaign as an alternative to sending Christmas cards and E-cards. We wish all our clients and contacts a Happy Christmas and prosperous New Year. *****

********* This email is sent for and on behalf of Eversheds LLP *********

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Operation ROCHESTER .
Summary of expert evidence.
Ten cases of alleged negligence.
6th June 2006.

Overview.

Operation ROCHESTER is an investigation into 92 deaths of elderly Gosport War Memorial Hospital patients between 1988 and 2000.

It follows allegations initially made in 1998 that the death of patients was being hastened through the inappropriate and excessive administration of Diamorphine in many cases delivered by way of syringe driver.

Recent expert evidence raises further significant concerns in a small number of cases that the care afforded to patients was 'negligent' to a point that it contributed 'more than minimally' towards the death of the patient. These matters continue to be investigated as potential homicides.

Following police investigation in 2001/2 files of evidence were placed before the Crown Prosecution Service in respect of the death of five patients, Cunningham, Richards, Wilkie, Wilson and Page, the common denominator being that prior to death Diamorphine was prescribed by Dr Jane BARTON. CPS determined on 28th November 2002 that there was 'no reliable evidence that the named patients were unlawfully killed'.

The police investigation was resurrected in September 2002 following concerns raised by nursing staff around similar issues (the alleged excessive use of Diamorphine)

Subsequent enquiries revealed concerns raised by family members and healthcare professionals in respect of the standard of care afforded to 92 patients.

The patients medical case notes were recovered and reviewed by a team of medical experts (known as the key clinical team) in the fields of toxicology, general medicine, palliative care, geriatrics and nursing.

The cases were effectively 'categorised' as follows.

Category 1. (19 cases) No concerns. Optimal care delivered. The family members in respect of these cases have been informed that no further police action will be taken.

Category 2. (59 cases) 'Concerns' exist in that the medical team of experts assessed the care of these patients as 'sub optimal'. However, these cases have not been raised to the status of 'negligent', and as such it is highly unlikely that there will be any further police investigation into the particular circumstances. The family members have been informed of the category of the deceased and a summary of the care provided and attendant circumstances of death, by a legal/medico lawyer quality assuring the findings of the clinical team. Additionally the relevant category 2 case-file papers and medical notes have been forwarded to the GMC and Nursing and Midwifery counsel for their attention. Family members have been informed that these cases have been released from police investigation upon the basis that the criminal standard of proof could not be met.

Category 3. (14 cases) The medical team have assessed the care delivered in these cases as 'negligent.'

In four of the cat/3 cases however the death of the patients has been confirmed to be through 'natural causes'. These cases are shortly (June 2006) to be released from criminal investigation and forwarded to the GMC and NMC who no doubt will look to explore the potential 'negligence' issues.

There remain ten category 3 cases that have been assessed as 'negligent care' with the cause of death being 'unclear'. It is in these cases that a full police investigation has been conducted including the statementing of all relevant healthcare staff involved in the care of the patient prior to death, expert witness review of medical notes and geriatric and palliative care assessment, family group member statements, and interviews with healthcare staff under criminal caution.

It is anticipated that case-files in respect of all of these cases will have been passed to the CPS for their final consideration by 9th June 2006 or thereabouts (files have been submitted incrementally since December 2004).

This document provides an overview of these cases by summarising the initial findings of the multi-disciplinary team and the expert 'evidential' witnesses.

1. Arthur CUNNINGHAM.
    - Clinical team assessment - Negligent, medication possibly contributing towards cause of death bronchopneumonia.
    - Palliative expert - Appropriate levels of medication under the circumstances.
    - Geriatric expert - Appropriate management for terminal illness.

2. Elsie DEVINE.
    - Clinical team assessment - Negligent, cause of death unclear and use of opioids questionable.
    - Palliative expert - Doubt that patient had entered terminal phase, drugs excessive in any event. Recommends renal expert to assess whether terminal.

- Geriatric expert - Suggests irreversible kidney pathology. Drugs administered at a level higher than conventional guidance however terminally ill and appeared to receive good palliation for symptoms.
- Consultant Nephrologist - Worsening severe renal failure, possible to stabilise but prognosis death inevitable.

3. Sheila GREGORY.
   - Clinical team assessment - Negligent care, admitted for rehab for fractured neck of femur, no antibiotics given for chest infection.
   - Palliative expert - Natural decline into terminal phase dose of diamorphine unlikely to be excessive.
   - Geriatric expert - Admitted with a number of serious chronic diseases, satisfied death of natural causes.

4. Elsie LAVENDER.
   - Clinical team assessment - Suffered head injury or brain stem stroke, forms of analgesia other than diamorphine may have helped. A worrying five fold escalation when converting from morphine to diamorphine might have contributed towards death.
   - Palliative expert - Excessive doses of diamorphine and midazolam administered ultimately could have contributed more than minimally towards death. Reasonable doubt that patient had reached terminal phase and decline may have been reversible with appropriate treatment.
   - Geriatric expert - Failure to make proper assessment of multiple medical problems but likely to be entering terminal phase of life. Excessive doses of diamorphine and midazolam likely to cause respiratory depression. Cannot say beyond all reasonable doubt that life shortened.

5. Enid SPURGIN.
   - Clinical team assessment - Admitted following fractured hip, very high starting dose of diamorphine probably contributing towards death. No evidence of specialist consultation.
   - Palliative expert - Mrs SPURGIN not anticipated to be dying, doctors failed to adequately assess condition, symptoms in keeping with potentially reversible septicaemia/toxaemia. Exposed to inappropriate doses of diamorphine and midazolam that would have contributed more than minimally towards death.
   - Geriatric expert - Prognosis generally poor for fractures in the elderly. A number of areas of poor clinical practice in this case including lack of medical assessment, poor documentation and considering alternative analgesic regimes. High starting dose of diamorphine however unable to satisfy that death hastened by anything other than a short time (hours).
   - Orthopaedic expert - Suffered relatively complex hip fracture, significant bleed into thigh post operatively, of grave concern

that no further action can be identified in relation to a potentially serious and reversible diagnosis.

6. Robert WILSON.
   - Clinical team assessment - Admitted fracture left humerus, liver and kidney problems Code A Death presumably from an overdose of opiates in a man with poor opiate metabolism and reduced tolerance.
   - Palliative expert - Code A increases in diamorphine difficult to justify and likely to be excessive for needs, however difficult to state with certainty whether doses contributed more than minimally towards death.
   - Geriatric expert - Oramorphine dose not an appropriate clinical response to pain. Formed a major contribution toward clinical deterioration, the treatment negligent and more than minimally contributed towards the death of Mr WILSON.
   - Clinical governance expert - Mr WILSON suffered liver dysfunction and probably heart failure but the initiation of opiate medication an important factor leading to death. Might have left hospital alive had he not been commenced on opiate medication.
   - Gastroenterology expert - An unwell man whose life expectancy short but no attempt appears to have been made to justify the use of opiates in this 'at risk' patient group. Died of acute chronic (but reversible) liver failure precipitated by opiate medication.

7. Leslie PITTOCK.
   - Clinical team assessment - deteriorating physical and mental health, probably opiate toxic; cause of death unclear, opiates could have contributed.
   - Palliative expert - medical notes inadequate, pain not appropriately assessed, Opioids not appropriate to alleviate anxiety and agitation. Diamorphine excessive to need may have contributed more than minimally to death
   - Geriatric expert - Mr PITTOCK frail and dependent, at the end of chronic disease process of depression drug related side effects lasting 20 years. Starting dose of diamorphine 3 times greater than dose conventionally applied. Combination of drugs likely to have caused excessive sedation and may have shortened life by hours/days, but not beyond all reasonable doubt. Care sub-optimal but could not be proved negligent or criminally culpable.

8. Helena SERVICE.
   - Clinical team assessment – Old lady with many medical problems, diabetes, heart failure, confusion. Upon transfer was placed on sedation via syringe driver became less well and

diamorphine added, the need unclear and could have contributed towards her death.

- Palliative expert – Mrs SERVICE did not appear to be experiencing significant pain although opioids are used for breathlessness in end stage heart failure. Seek view of cardiologist. Not obviously in terminal stage, diamorphine dose excessive.
- Geriatric expert – Patient recorded as having long standing congestive heart failure. Cause of death multi-factorial. Drug doses higher than necessary and may have shortened life by hours, but not beyond all reasonable doubt.

9. Geoffrey PACKMAN.
    - Clinical team assessment – died of gastrointestinal bleed, not taken seriously and treated with opioids. Cause of death natural but potentially treatable and medical care terrible.
    - Gastroenterology expert – Limited medical assessment to bleed, managed by escalating doses of opiate analgesia. Transfer for endoscopic therapy should have been considered. Apparently no attempt to ascertain why patient had become so unwell.
    - Palliative expert – Transferred to dryad ward for rehabilitation. Inappropriate management of gastrointestinal haemorrhage together with exposure to unjustified and inappropriate doses of diamorphine and midazolam contributed more than minimally to death.
    - Geriatric expert – High risk patient, further bleed does not lead to medical attention, difficult clinical decision made without involvement of senior medical opinion, higher than conventional starting dose of diamorphine used without justification in notes. Despite the above deficiencies probably made little difference to outcome and died of natural causes.

10. Ruby LAKE
    - Palliative expert - Mrs Ruby Lake was a frail 84 year old who was admitted to hospital having fallen and fractured her left hip on 5th August 1998. This was surgically repaired and she had a difficult post-operative course due to events associated with her pre-existing heart and kidney problems, leading to heart failure, atrial fibrillation and renal impairment, along with a chest infection and episodic confusion/agitation at night. Apart from these episodes of pain, Mrs Lake appeared to be progressing rather than deteriorating whilst awaiting transfer to Gosport War Memorial Hospital and had begun to mobilise. Mrs LAKE not provided a good standard of care, poor notes make it difficult to understand her rapid deterioration. It is possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered. Reasonable doubt exists that she had entered her terminal

phase, and she was exposed to doses of midazolam and diamorphine that could have contributed more than minimally towards her death.

- Geriatric expert - Ruby Lake was an 84-year-old lady with a number of chronic diseases, she suffered a fall and a fractured neck of femur in August 1998. She was admitted to hospital and had operative treatment but developed post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorated and died in the Gosport War Memorial Hospital. The combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care. It is impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held. Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However the expert is unable to satisfy himself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

Wider expert case summaries.

Clinical Team assessment.

1. Arthur CUNNINGHAM. 79. Died 26th September 1998 five days after admission to Gosport War Memorial Hospital, suffering Parkinson's disease, dementia, myelodysplasia, admitted from a nursing home with 'difficult behaviour'.

Admitted from day hospital with a large necrotic sacral sore which would have been painful but the reasons quoted for starting the diamorphine/midazolam infusion were related to behaviour.

No mention of pain on the 25th and 26th September but the dose of Diamorphine was increased on both days.

Cause of death was 'Bronchopneumonia' although the medication might have contributed to it. Several doctors involved in care and a rapid escalation of Diamorphine and high doses of Midazolam were administered.

Palliative expert - There appears little doubt that Mr Cunningham was 'naturally' coming to the end of his life. His death was in keeping with a progressive irreversible physical decline, documented over at least 10 days by different clinical teams, accompanied in his terminal phase by a bronchopneumonia. Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mr Cunningham a peaceful death, albeit with what appears to be an apparent lack of sufficient knowledge, illustrated, for example, by the reliance on large dose range of diamorphine by syringe driver

rather than a fixed dose along with the provision of smaller 'as required' doses that would allow Mr Cunningham's needs to guide the dose titration.

Dr Barton could also be seen as a doctor who breached the duty of care she owed to Mr Cunningham by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Cunningham by unnecessarily exposing him to potentially receiving excessive doses of diamorphine.

In the event, however, such large doses were not administered, and in the experts opinion, the use of diamorphine, midazolam and hyoscine in these doses could be seen as appropriate given Mr Cunningham's circumstances.

Geriatric expert - Mr Arthur Cunningham a 79 year-old gentleman, suffered from long-standing Parkinson's disease with multiple complications followed by a fairly rapid decline in health leading to his first admission to the Gosport War Memorial Hospital on 21st July, 1998 and a final admission 21st September, 1998.

He received terminal care including subcutaneous Diamorphine and Midazolam through a syringe driver and died on 26th September 1998. The expert opinion is:

Arthur Cunningham is an example of complex and challenging problems in geriatric medicine. He suffered from multiple chronic diseases and gradually deteriorated with increasing medical and physical dependency. It is always a challenge to clinicians to identify the point at which to stop trying to deal with each individual problem or crisis, to an acceptance that the patient is dying and that symptom control is appropriate.

Mr Cunningham was managed appropriately, including the decision to start a syringe driver for managing his symptoms and agitation as part of his terminal illness in September 1998.

The experts one concern is the increased dose of Diamorphine in the syringe driver on 25th and 26th September 1998. The expert was unable to find any justification for this increase in dosage in either the nursing or the medical notes. This increase in medication may have slightly shortened life for at most no more than a few hours to days. However the expert was not able to find evidence to satisfy that this is to the standard of 'beyond reasonable doubt'.

Clinical team assessment.

2. Elsie DEVINE. 88 died 21st November 1999 32 days after admission to Gosport War Memorial Hospital. She had suffered multi-infarct dementia, moderate/chronic renal failure and paraproteinaemia. She had been occasionally aggressive and restless being prescribed thioridazine for this.

When she became more agitated, she was started on fentanyl, and then converted to large doses of diamorphine and midazolam via a syringe driver. Pain was not raised as an issue. Cause of death (chronic renal failure) is not clear and the use of opiods questionable, especially when considering doses. An issue over whether or not she was dying before given Fentanyl which was inappropriately prescribed for sedation.

Palliative expert-

Mrs Devine was a frail 88yr old with significant medical problems.

A fentanyl transdermal patch was commenced for an unspecified reason. The following day Mrs DEVINE became more confused and agitated. An injection of chlorpromazine was given and a syringe driver started one hour later containing diamorphine and midazolam. She died 2 days later.

The medical care provided by Dr BARTON was sub optimal, there was a failure to keep clear accurate and contemporaneous patient records, there was an inadequate assessment of Mrs DEVINES condition, treatment's were prescribed that appeared excessive for her needs.

In particular the prescription of fentanyl and diamorphine appear unjustified and/or excessive for Mrs DEVINES needs.

The use of chlorpromazine and midazolam appears justifiable on the grounds of Mrs DEVINES confusion, but the doses used were excessive for her needs.

There is a reasonable doubt that she had definitely entered her terminal stage.

If it were that Mrs DEVINE had naturally entered the terminal phase of her life at best Dr BARTON could be seen as a doctor who whilst failing to keep clear accurate and contemporaneous patient records had in good faith been attempting to allow a peaceful death, albeit with what appears to be inappropriate and excessive use of medication due to a sufficient lack of knowledge.

At worst DR BARTON could be seen as a doctor who breached the duty of care she owed to Mrs DEVINE, by failing to provide treatment with a reasonable amount of skill and care.

This was to a degree that disregarded the safety of Mrs DEVINE by unnecessarily exposing her to inappropriate and excessive doses of medications as with the fentanyl which could have resulted in a worsening of her agitation and confusion.

Dr BARTON'S response to this was to further expose Mrs DEVINE to inappropriate and/or excessive doses of midazolam and diamorphine that could have contributed more than minimally negligibly or trivially to her death.

As a result Dr BARTON lays herself open to the accusation of gross negligence.

Mrs DEVINES death was not typical of patients dying from chronic renal failure.

Mrs DEVINE was incorrectly labelled as having 'myeloma' in the admission notes, this mistake is important if it influenced how the patient was managed eg deterioration could be incorrectly considered an 'expected' irreversible terminal event due to her cancer like condition.

It is difficult to endorse prescribing action morphine on the day of transfer that results in the use of an above average dose of a strong opioid as a first line analgesic in a frail elderly patient(against company prescribing advice). Medication was excessive even if it were considered she was dying of natural causes.

Increasing doses of opioids excessive to a patients needs are also associated with an increasing risk of delirium, nausea and vomiting and respiratory depression. Once unresponsive and not drinking Mrs DEVINES renal function would decline further.

In the absence of pain shortness of breath or cough in my view there is no justification for the use off diamorphine by syringe driver.

A starting dose of 5-10mg a day would have been more appropriate.

Geriatric expert-

This case presents as an example of the most complex and challenging problems in geriatric medicine.

Physicians including a renal physician and a haematologist all conclude that she suffered from a progressive problem with no easily treatable or remedial cause, the small kidneys shown on ultrasound usually suggest irreversible kidney pathology.

The mental health team describe increasing confusion and mental deterioration over the course of the year.

The major problem in deciding whether care is sub –optimal is the lack of documentation.

The drug management was sub-optimal, there was no apparent justification for the Diamorphine to be written up prn on admission to Gosport.

The logic for the prescription of Fentanyl is not explained.

There was a three hour overlap, between the prescription of the subcutaneous Diamorphine and Midazolam and the removal of the Fentanyl patch.

The starting doses of both Midazolam and Diamorphine were higher than conventional guidance, which may have shortened her life by a short period of time, this would have no more than hours to days (but she was also out of distress for the last 58hrs)

However she was terminally ill and appeared to receive good palliation of her symptoms.

It is not clear whether any advice was sought (by DR BARTON) from the consultant legally responsible for the care of this patient (DR REID) in respect of the administration of Fentanyl on 18th November 1999.

In my opinion on 19th November patient was terminally ill, on balance many clinicians would come to the same conclusion after a month in hospital.

In my view the death certificate would appropriately say acute renal failure, chronic glonerulonephritis, paraproteinemia and dementia.

The prediction of how long a terminally ill patient will live is virtually impossible, and even palliative experts show an enormous variation.

Whilst her care was sub-optimal I cannot prove it to be negligent or criminally culpable.

I am not able to say that the use of Fentanyl, Diamorphine and Midazolam were prescribed with the intention of deliberately shortening her life or had the definite effect of shortening her life in more than a minor fashion.

Expert Consultant Nephrologist-

Mrs DEVINE was admitted as an emergency to hospital with an acute confusional state for which no other cause other than multi-infarct dementia and severe renal impairment could be found.

After a period of stabilisation, her clinical condition worsened with severe renal failure and worsening agitation and restlessness.

Although it may have been possible to stabilise her condition with relatively simple measures, this would not have materially changed her prognosis as death was inevitable.

Clinical team assessment.

3. Sheila GREGORY. 91 died 22nd November 1999 81 days after admission to Gosport War Memorial Hospital, she had suffered a fractured neck of the femur and other medical problems. The original aim was rehabilitation, but there was an early entry about keeping her comfortable. There was a suggestion of a stroke early in her stay, at GWMH and she deteriorated. The decision was made to refer her to Nursing Home for care because she was unlikely to improve further. She then deteriorated with distress and breathlessness. The staff wondered about a chest infection but did not start antibiotics. Oromorph helped the distress and breathlessness, so she was started on a reasonably low dose of diamorphine through a syringe driver. Frusemide as a diuretic was given in case the breathlessness was due to fluid on the lungs. In the end the cause of death was not entirely clear (recorded as Bronchopneumonia) Should they have tried antibiotics or explained why they were not used? She probably would have died whatever was done from 15.11.1999.

Palliative expert - Mrs Gregory's decline was noted over a number of weeks and this would be in keeping with a natural decline into a terminal phase. Further, whatever the reason was for the use of diamorphine the physical findings on the day of Mrs Gregory's death would suggest that the dose she was receiving was unlikely to have been excessive to the degree that it rendered her unresponsive or was associated with respiratory depression.

Geriatric expert - Sheila Gregory a 91 year old lady with a number of serious chronic diseases suffers a fall and fractured neck of femur in August 1999. She is admitted to the Haslar Hospital and making little rehabilitation progress, with a very poor prognosis she is transferred to the Gosport War Memorial Hospital.

There is some weakness in the documentation of her condition in particular on her admission to the Gosport War Memorial Hospital and on the 18th November when her definitive final clinical deterioration is documented. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to patient's and any drugs or other treatment prescribed". The lack of clinical examination both on admission and more important Mrs Gregory care, deteriorated represents poor clinical practice to the standards set by the General Medical Council.

Despite the above the expert is satisfied that Mrs Gregory's death was of natural causes and that her overall clinical management in Gosport was just adequate.

Clinical team assessment.

4. Elsie LAVENDER. 83. Died 6th March 1996, 14 days after admission to Gosport War Memorial Hospital, she had been suffering head injury or brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. It was possibly musculoskeletal pain from a fall downstairs. Other forms of analgesia such as anti-inflammatory drugs or hot/cold packs might have worked. The most worrying aspect is the large dose escalation when converting morphine to diamorphine via syringe driver (Five fold increase). The cause of death is unclear (cerebovascular accident) and the dose escalation might have contributed.

Palliative expert-

The medical notes were inadequate and the cause and treatment of Mrs LAVENDER'S urinary tract infection was not properly assessed/ treated.

The Morphine may have been inappropriate or excessive to the type of pain experienced and the possible role this played in her deterioration was not considered. Treatments were continued that may have aggravated her condition ie the diuretic.

Excessive doses of diamorphine/ midazolam were administered from 26th February 1996.

Blood tests of 27th February 1996 revealed low platelet count and deteriorating kidney function, not reflected in the notes and no action taken, not discussed with a consultant or specialist advice.

On 29th February 1996 no mention made of high blood sugar requiring high doses of insulin. No mention of pain in medical notes therefore inconsistent with nursing notes.

No pain assessment recorded against increase in morphine of 4th March 1996.

The reported deterioration mentioned in the notes of 5th March is not explained.

There is reasonable doubt that Mrs LAVENDER had reached her terminal phase. Causes of her decline may have been reversible with appropriate treatment.

Ultimately excessive doses of diamorphine and midazolam could have contributed more than minimally trivially or negligibly towards her death, Dr BARTON leaves herself open to the accusation of gross negligence.

Cause of death registered as cerebrovascular accident, validity difficult to comment upon but final deterioration does not seem typical of cerebrovascular accident, more likely immobility from fall leading to infection.

Geriatric expert-

Patient suffered long standing multiple medical problems, after admission found to be doubly incontinent, totally dependent, suffering constant pain to shoulders and arms and found to have serious abnormalities in various blood tests.

Increasing physical dependency and increased patient distress.

Doctors and consultants failed to make adequate medical assessment and diagnosis of her condition.

A belief that Mrs LAVENDER was misdiagnosed and had suffered a quadriplegia from a high cervical spinal cord injury secondary to her fall.

Abnormal blood tests could have represented systemic illness such as cancer of the bone marrow, the test should have been commented upon by the doctor in charge of the case as to their relevance.

The lack of examination and comment on abnormal blood tests make it impossible to assess the care as sub optimal, negligent or criminally culpable.

It was likely that Mrs LAVENDER had several serious illnesses and was entering the terminal phase of her life.

Mrs LAVENDER received a 'negligent' medical assessment both at Haslar and Gosport War Memorial Hospital, in particular she was not examined on admission to Gosport. No medical diagnosis made for pain, which would fit with spinal cord fracture. Without appropriate assessment impossible to plan appropriate management.

The two options were to either get further specialist opinion or provide palliative care it would have been wise to obtain specialist opinion, probably from the consultant in charge of the case. There is no evidence that this was done.

Unusually large dose of diamorphine written up on 26th February 1996, and subsequent excessive dose reported on 5th March 1996, together with high dose of Midazolam likely to cause excessive sedation and respiratory depression.

However this expert cannot say beyond all reasonable doubt that Mrs LAVENDERS life was shortened.

Clinical team assessment.

5. Enid SPURGIN.92. Died 12th April 1999 eighteen days after admission to Gosport War memorial hospital. She had suffered a fractured hip which had

been repaired with a dynamic hip screw. She could get from a bed to a chair with the help of 2 nurses before the transfer, and had paracetomal as required for pain relief.

Pain became an issue as soon as she arrived at Dryad. Analgesia was started with Oramorph regularly and then regular codydramol and then MST at low dose. The dose was increased after continued pain was noted. She had deteriorated on the day a syringe driver was started, but she is reported as denying pain. Diamorphine was started at 80mg per 24hrs via a syringe driver. This is a very high dose 5-6 fold increase. It is not clear who chose this dose but the way the drug was prescribed the nurses could have used a dose anywhere between 20 to 200 mg a day. It had to be reduced, because she was too drowsy and it probably contributed to her death. No evidence of consultation with appropriate specialist over the management of her operation wound infection. Rapid escalation of opiate dose. Poor drug prescription when diamorphine infusion was commenced, nurse could have set up anything from a dose of 20-200 mg per day and still been in compliance.

Palliative expert-

Mrs Spurgin was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999. Within hours of the surgery there was leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs Spurgin's hip/thigh on movement continued to be a problem noted by Dr Reid when he reviewed Mrs Spurgin on the 24th March 1999. Surgeon Commander Scott reviewed Mrs Spurgin but no specific comment was recorded in the medical notes regarding Mrs Spurgin's pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Mrs Spurgin in Haslar Hospital, the report of expert orthopaedic surgeon raises several concerns.

During her admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Mrs Spurgin's condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam was in doses excessive to Mrs Spurgin's needs.

When Mrs Spurgin became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented.

Mrs Spurgin was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/ toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites

due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist.

Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Dr Reid, as a result of finding Mrs Spurgin unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Geriatric expert-

Mrs Enid Spurgin presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture.

The prognosis after such a fracture, particularly in those with impairments of daily living before their fracture is generally poor both in terms of mortality or morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications.

A significant problem in Mrs Spurgins case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, '(GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include – taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

The expert comments that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport, the failure to address the cause of this lady's pain or to consider any other actions from 26th March until 7th April, the use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

Subsequent management of Mrs Spurgin's pain was within current practice with the exception of the starting dose of Diamorphine (80mg in the syringe drive is at best poor clinical judgement). However, the expert was unable to satisfy beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

Consultant Orthopaedic Surgeon-

Mrs Spurgin suffered a relatively complex hip fracture as a result of her fall on March 19th 1999. The decision to operate and the implants and operative technique employed were appropriate. The expert was unable to comment on the quality of the fixation of the fracture in the absence of radiographic record or post mortem findings.

The patient had a significant bleed into her thigh in the early stages post-operatively, and the possibility of compartment syndrome was raised. It is of grave concern that no further action can be identified in relation to this potentially serious and reversible diagnosis. Consequently, it is not possible to confirm that she had a compartment syndrome from the medical record.

Due consideration of the significance of her symptoms of pain and her inability to mobilise was not given consistently at either Haslar or at Gosport War Memorial Hospital. Specifically she did not undergo a further x-ray examination at either hospital, and she was not referred back to Haslar from Gosport War Memorial Hospital. The differential diagnosis should have included implant failure and uncontrolled infection. These complications would have been reversible.

Clinical team assessment.

6. Robert WILSON. 74. Died 18th October 1998 four days after admission to Gosport War memorial Hospital, he is recorded Code A Code A poor nutritional status. He was admitted with a fracture of the left humerus.

During his last days on Dickens ward, he was on regular paracetomal and codeine as required needing one dose of codeine most days. On transfer to

dryad, he received 2 doses of oramorph and was then put on a moderate dose of oramorph every 4 hours with paracetomal as required. Liver and kidney problems make the body more sensitive to the effects of oramorph. He had both of these problems. He deteriorated, and was converted to a syringe driver at a dose, which was a close conversion from the oramorph dose.

Over the next 2 days the dose was increased without obvious indication. Death was presumably from overdose of opiates, in a man with a poor opiate metabolism, and reduced tolerance.

Unless the decision had been taken to treat pain 'regardless' then this was negligent. The initial dose of Morphine was inappropriate in a person with known Code A A rapid increase in body weight was documented in notes, with no apparent clinical response.

Palliative expert –

Mr Wilson was a 74 year old man who was admitted to hospital after falling over and fracturing the greater tuberosity of his left humerus. He had multiple serious medical problems; Code A leading to liver failure and encephalopathy, heart failure and kidney failure. Other problems included early dementia, depression and a high level of dependency.

Although the care he received at Queen Alexander Hospital led to Mr Wilson being mentally more alert and returned his kidney function to normal, he continued to become increasingly oedematous despite the re-introduction of his diuretic therapy which was considered due to heart failure. The pain he experienced from his fracture progressively improved as anticipated and during his time at Queen Alexander Hospital, his daily analgesic requirements reduced from the equivalent of 20mg to 3mg of oral morphine. Nevertheless, given the time it takes for a fracture to heal, it was not surprising that pain on movement was still present at the time of his transfer.

There are no concerns regarding the care proffered to Mr Wilson at the Queen Alexander Hospital.

On transfer to Dryad Ward, the care proffered to Mr Wilson by Dr Barton and Dr Knapman fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient (Dr Barton and Dr Knapman) and providing treatment that could be excessive to the patients needs (Dr Barton).

No pain assessment was carried out on Mr Wilson, but his only regular analgesic, paracetamol, was discontinued and prescribed p.r.n. (as required). Instead of his usual codeine 15–30mg p.r.n., approximately equivalent to morphine 1.5–3mg, he was prescribed morphine 5–10mg p.r.n. for pain relief. He received two doses of 10mg (a total of 20mg/24h) and the next day commenced on regular morphine 10mg every 4h and 20mg at night. In total he received 50mg of morphine in this 24h period, representing a larger dose

than that he received in the initial 24h after his fracture. This is against the general expectation that pain from a fracture would have been improving over time and, without a clearly documented pain assessment, it is difficult to justify. However, the impact of this dose of morphine on Mr Wilson is impossible to judge because he deteriorated rapidly in the early hours of the 16th October 1998.

The nature of his rapid decline and subsequent death were in keeping with worsening heart failure with or without a sudden event such as a heart attack. This, combined with his liver failure, could easily have precipitated his terminal decline. His reduced level of consciousness could have been due to a hepatic coma precipitated by the morphine or by a reduced level of blood oxygen secondary to the excess fluid on the lungs (pulmonary oedema) due to the heart failure. Later that day a syringe driver was commenced containing diamorphine 20mg/24h and increased over the next 48h to 60mg/24h, equivalent to oral morphine 120–180mg/24h. This increase in dose appears difficult to justify, as Mr Wilson was not reported to be distressed by pain, breathlessness or the secretions and was likely to be excessive for his needs. However, because heart and liver failure could also have led to a reduced level of consciousness, in my opinion, it is difficult to state with any certainty that the doses of morphine or diamorphine he received would have contributed more than minimally, negligibly or trivially to his death.

Geriatric expert-

Mr Robert Wilson a 74 year old gentleman Code A Code A who was admitted with a complex and painful fracture of the left upper humerus. His physical condition deteriorates at first in hospital, with alteration in mental state, renal impairment and subsequent gross fluid retention. He then starts to improve and is transferred to the Gosport War Memorial Hospital for further assessment and possible rehabilitation or continuing care. He is started on regular oral strong opiate analgesia for pain in his left arm and rapidly deteriorates and dies within 5 days of admission.

There is weakness in the documentation of his condition, in particular on the admission to the Gosport War Memorial Hospital on 14th October, and on the15th October when the regular oral strong opiate analgesia is commenced. If clinical examinations were undertaken they have not been recorded. General Medical Practice (GMC2001) states that "good clinical care must include adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must provide clear, accurate, legible and contemporaneous patient records which must report the relevant clinical findings, the decisions made, the information given to the patient and any drugs or other treatments provided". The lack of clinical examination on admission and on the day of 15th October when the decision was made to start regular strong oral opiate analgesia represents poor clinical practice to the standards set by the General Medical Council.

It is the expert's belief that the prescription of a total of 50 mgs of Oramorphine on the 15th October following the 20 mgs that were given on the 14th October was not an appropriate clinical response to the pain in Mr Wilson's left arm.

This dose of analgesia formed a major contribution to the clinical deterioration that occurred over the 15th-16th October, in particular, his rapid mental state deterioration. In the experts view this treatment was negligent, and more than minimally contributed to the death of Mr Robert Wilson on 19th October.

Clinical governance expert.

Studied the records provided by Hampshire Constabulary in order to consider three issues – the certified cause of death, the prescription of opiates and sedatives, and whether Mr Wilson fell into the category of patients who might have left hospital alive.

With respect to death certification the expert concluded that the certificate was inaccurate in that Mr Wilson did not have renal failure, and had liver dysfunction but not failure. He probably did have heart failure, although the expert believed the initiation of opiate medication was an important factor in leading to death.

With respect to the prescription of opiate drugs the expert concluded that on evidence available, that the initiation of opiate medication on transfer to Dryad ward was inappropriate. The expert also concluded that the starting dose was too high. The prescription of hyoscine and midazolam was justified by the use of opiates.

With respect to leaving hospital alive, it was concluded that Mr Wilson was in the category of patients who might have left hospital alive if he had not been commenced on opiate medicate on transfer to Dryad ward.

In the experts opinion, Mr Wilson had liver dysfunction but not full blown failure. His liver dysfunction did not cause death. In the presence of other life-threatening conditions, the liver dysfunction may impair the ability to recover, and it would have been reasonable to mention on the death certificate that Mr Wilson had chronic liver disease. The cause of his liver disease Code A was not mentioned on the certificate.

Mr Wilson did not have renal failure. He did have abnormal blood test results after his admission to hospital, but these improved with re-hydration. Mr Wilson probably did have cardiac failure. There may have been other conditions as well. Haemoglobin estimations during his admission to Queen Alexandra Hospital had indicated mild anaemia. If this condition had deteriorated, the heart failure would also have become worse. However this was rather unlikely since he was being closely observed in Queen Alexandra Hospital and signs of increasing anaemia would almost certainly have been recognised. Evidence of bleeding would have been noted if it had occurred. There is no convincing evidence in the

records to confirm a diagnosis of myocardial infarction such as history of chest pain, raised cardiac enzymes or ECG evidence. One could also speculate about possible occurrence of some unsuspected condition.

However, despite all these speculations, it has to be acknowledged that his decline was associated with the regular administration of morphine, and was responded to by administration of diamorphine by syringe driver.

The reason for commencing Oramorph is not recorded in the medical notes [179]; in particular, the reasons for not using a non-opiate drug for pain relief are not given. Even if Mr Wilson did have pain from the fracture that was not controlled by paracetamol, regular does of 10mg of oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed to adequately reduce the pain, a low dose of morphine (2.5-5mg) as had been used in the early days of his admission might have been reasonable. Although Mr Wilson did have congestive cardiac failure, therefore his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of Oramorph on 14/10/98.

It is important to note that the general standard of completion of death certificates is unsatisfactory. For example, in a review of 1000 counterfoils of certificates in one teaching hospital in 1999-2000, only 55% of certificates had been completed to a minimally accepted standard (Swift and West, 2002). Of the remaining certificates, 25% had incomplete data, in 11% the part II section had been used inappropriately, and 9% were illogical or inappropriate. In her third report from the Shipman Inquiry, Dame Janet Smith observed: *A further problem with the current system is that the quality of certification is poor. Doctors receive little training in death certification.* (paragraph 17, page 4, Shipman Inquiry). The standard of completion of the death certificate in Mr Wilson's case should therefore be regarded as fairly typical. Although Mr Wilson did not have renal failure, the history of recent abnormal renal function tests prompted use of this diagnosis; the mention of liver failure was probably a convenient way of describing the impaired liver function.

<u>Consultant Gastroenterologist.</u>

The management of Mr Wilson's liver condition following the time of initial admission was not perfect but reasonable. He should have received Pabrenex to prevent *Wernickes'* encephalopathy in addition to lactulose to treat *hepatic* encephalopathy.

Mr Wilson was assessed by a psychogeriatrician who did not detect any of the classical signs of Wernickes' encephalopathy. During most of his admission as well Mr Wilson was generally alert and so the omission of lactulose or other anti-encephalopathy treatment cannot be cited as a major omission. In real-life I suspect Mr Wilson would have refused to take lactulose for presumed encephalopathy because of its taste and laxative effects.

Mr Wilson was clearly an un-well man whose life expectancy was short. His previous record demonstrates that he would have been likely to return to drinking on discharge from hospital. The administration of high doses of morphine whilst an in-patient on Dryad however must be considered reckless. Warnings about morphine usage in the context of liver disease are readily available in standard prescribing guides such as those cited from the BNF. No attempt appears to have been made to justify the use of opiates in this at risk patient group. There also does not appear to have been any attention paid to appropriate dose reduction and/or monitoring in Mr Wilson's case. The outcome was predictable in the clinical context of cirrhosis and escalating opiate dosage that Mr Wilson could not have survived.

Mr Wilsons cause of death is given as (1) Congestive Cardiac Failure (2) Renal failure and (3) Liver failure. The experts understanding was that this was a clinical diagnosis as opposed to a post-mortem finding.

Congestive cardiac failure was unlikely to be the primary cause of death in Mr Wilsons case. Mr Wilson had oedema and the *commonest* cause for oedema is as a consequence of heart failure. However oedema also occurs in cirrhotic liver disease and in the experts view this was far more likely cause of oedema and ultimate demise than heart failure.

Mr Wilson had cirrhosis and therefore cause of death (3) 'liver failure' was reasonable. Mr Wilson had signs of *chronic* liver failure throughout his hospital stay including oedema and probable hepatic encephalopathy. The experts view is that he died of *acute chronic* liver failure precipitated by opiate medication.

Renal failure is a common secondary consequence of liver failure.

While there is limited evidence to support a diagnosis of 'renal failure' it is a common complication of liver disease. Mr Wilson is likely to have had the 'hepatorenal syndrome.' This means reversible renal failure as a direct consequence of the liver failure. If the liver injury can in some way be reversed then the renal failure will correct.

Clinical Team assessment.

7. Leslie PITTOCK. 82. Died 24th January 1996, 15 days after admission to Gosport War Memorial Hospital. He was physically and mentally frail deteriorating on a mental health ward. Medical notes state pain in flexed right hand. Nursing notes state generalised pain. Arthrotec tried plus oramorph. A syringe driver started five days later with a large dose increase when converting from oramorph to diamorphine. Notes on the 21st January 1996 record a respiratory rate of 6 per minute, likely as a reflection of the dose of opiates ie he was probably opiate toxic but the dose was not reduced. Cause

of death unclear, although he was very frail, but opiates could have contributed.

Palliative expert.

Medical case-notes inadequate and pain not appropriately assessed. Opioids were not appropriate as administered to alleviate anxiety and agitation.

It was not necessary to use a syringe driver (unless the patient unwilling or unable to take medicines orally)

Doses of diamorphine 40-120mgs were excessive to needs of the patient (far exceeding appropriate starting dose of 10-15mgs.

There was little doubt that Mr PITTOCK was naturally coming to the end of his life.

At best DR BARTON had attempted to allow a peaceful death, albeit with excessive use of diamorphine.

Experts opinion was that Dr BARTON breached her duty of care, by failing to provide treatment with skill and care, it was difficult to exclude completely the possibility that a dose of diamorphine that was excessive to his needs and may have contributed more than minimally negligibly or trivially to his death. Dr BARTON leaves herself open to the accusation of gross negligence.

Given the nature of Mr PITTOCKS decline, Bronchopneumonia appears to be the most likely cause of death.

Geriatric expert.

Reports that Mr PITTOCK was extremely frail and dependent, and at the end of a chronic disease process of depression and drug related side effects spanning 20 or more years.

There was a problem in the expert assessing care due to lack of documentation.

The lack of notes represented poor clinical practice, no written justification for high doses of Diamorphine and Midazolam.

Drug management afforded to the patient was sub-optimal.

The starting dose of 80mgs of diamorphine was approximately 3 times the dose that would conventionally be applied.

A combination of higher than standard doses of drugs, Diamorphine, and Midazolam combined with Nozinan is likely to have caused excessive sedation and may have shortened life by a short period of time, hours to days. Whilst care was sub-optimal it could not be proved to be negligent or criminally culpable.

Predictions of how long terminally ill patients live are impossible, even palliative care experts show enormous variation.

Medication is likely to have shortened life but not beyond all reasonable doubt.

Clinical Team assessment.

8. Helena SERVICE. 99. Died 5th June 1997, two days after admission to Gosport War Memorial Hospital. This lady was very old, and had many medical problems including diabetes, heart failure, confusion and sore skin.

She was 'agitated' in the Queen Alexandra hospital but they accepted it and used thioridazine orally. Upon transfer to Gosport War Memorial Hospital, she was placed on sedation via a syringe driver at night. She became less well the next day and diamorphine was added to the driver (she had not required analgesia other than paracetomal at the Q.A.H). Mrs SERVICE died the following day.

Medication could have contributed towards her death, the need for such medication was not clear.

Palliative expert.

Mrs SERVICE did not appear to be experiencing significant pain although opioids are use for breathlessness in end stage heart failure.

The opinion of a cardiologist should be sought on Mrs Service's likely prognosis, scope for optimising her heart failure therapy and the role of opioids in chronic heart failure in 1997.

On Mrs Service's first night on Dryad ward she was commenced on a syringe driver containing midazolam in a dose sufficient to sedate an elderly patient. This in the experts opinion appeared to be an excessive reaction to what is a well recognised understandable response of a confused patient to new surroundings. Mrs Service was not obviously at her terminal stage but was elderly, hard of hearing, confused/prone to confusion, spending her first night in a new environment with new staff and her usual night sedation was not given.

Subsequently the increase in midazolam to 40mg and the addition of diamorphine 20mg over 24hrs are without justification in the medical and nursing notes.

Blood tests on 4th June 1997 show Mrs Service was dehydrated a reversible problem treated previously on F.1 ward (Queen Alexandra Hospital)

There is no comment in the notes about these results and why it was not felt appropriate to act on them. If it were considered that Mrs Service was actively dying then it would have been reasonable not to have re-hydrated her and the use of diamorphine and midazolam could be justified, albeit that the dose of diamorphine was excessive for her needs.

If it were that Mrs Service were not actively dying as the notes on her transfer to Dryad ward suggest then the failure to re-hydrate her together with the use of midazolam and diamorphine would have contributed more than minimally, negligibly or trivially to her death.

However, given that elderly frail patients with significant medical morbidity can deteriorate with little or sometimes no warning it could be argued that it would be difficult to ultimately distinguish which of the above was most likely without any doubt.

Geriatric expert.

Admitted to Queen Alexandra Hospital on 17th May 1997 at the age of 99 at the request of her GP to hospital with confusion, disorientation and progressive failure for the rest home to be able to cope with.

Diagnosed to have a combination of dehydration and left ventricular failure.

Recorded as having long standing congestive cardiac failure.

Transferred to Gosport War Memorial Hospital on 3rd June, confused, diabetes and heart failure.

The cause of death in the view of the expert was 'multi-factorial'. The dose of 20mg of diamorphine combined with the 40mg dose of midazolam was higher than necessary in this very elderly and frail lady's terminal care and the medication may have slightly shortened life although this opinion was not reach the standard of proof of beyond all reasonable doubt. The expert would have expected a difference (of survival) of at most no more than a few hours or days had a lower dose been used.

Clinical team member assessment (Geriatrician.)

9. Geoffrey PACKMAN. 67 years died 3rd September 1999 thirteen days after transfer to Gosport War Memorial hospital.

'I have more concerns with this case than the other members of the team. This man was treated for a myocardial infarction but died of a gastrointestinal bleed. I have been told that this was considered as the diagnosis in Queen Alexandra Hospital and the decision was made not to treat it. I have not found this and I believe they did not take this seriously in GWMH and treated him with opiates. I consider the cause of death to be natural (although potentially treatable) and the medical care terrible.

Quality assurance comment.

Mr PACKMAN was admitted to Gosport War Memorial Hospital in July 1999 with an irritating rash on his side and groin. It appears from the medical notes that he had an episode of black stools prior to being discharged from Portsmouth Hospitals NHS trust.

Following admission to Gosport War memorial Hospital on 23rd August 1999 Mr PACKMAN was noted as remaining very poorly with no appetite. It was noted in Mr PACKMANS nursing records that he was passing fresh blood per rectum on 25th August 1999.

On 26th August 1999 he complained of feeling unwell with indigestion pain in his throat together with nausea and vomiting.

At this point he was commenced on opiate medication. No active measures were taken to resuscitate Mr PACKMAN and following rapidly increasing doses of Diamorphine he died on 3rd September 1999.

There is a variation in the view taken of this case by the experts reviewing the notes. Concern is expressed by the geriatrician that although the death was natural the gastrointestinal bleed was potentially treatable.

An expert report from a gastrointestinal surgeon/physician is to be sought.

Expert Gastroentorologist.

Mr PACKMAN did not experience a significant life threatening gastrointestinal bleed while an in patient at Portsmouth Hospital. He developed a mild anemia of chronic disease secondary to his underlying medical problems during that part of his admission. His medical state was stable and there was no medical reasons to delay transfer to a 'step down' care facility from an acute hospital.

Mr PACKMAN is likely to have suffered a significant gastrointestinal bleed while an out patient at Gosport War Memorial Hospital (approx 3 days after transfer) Medical assessment at that time was limited and was managed with escalating doses of opiate analgesia before he died on 3rd September 1999.

His main problems recorded throughout his stay were obesity, leg oedema, cellulites, poor mobility, arthritis and pressure sores. His mental state was very good and he had no pain. Overall he doesn't look ill and it was mainly a nursing problem.

During the admission period at the previous hospital the only analgesia he received was paracetamol.

Following the passing of rectal blood a non urgent sigmoidoscopy examination would have been desirable to confirm haemorrhoids and exclude bowel cancer. Transfer for endoscopic therapy should have been considered.

There is no attempt apparently made to ascertain why Mr PACKMAN had become so acutely unwell.

Mr PACKMAN was obese. He would represent a high risk for surgery. It would be difficult to justify the potential mortality of elective surgery in a morbidly obese patient.

Palliative expert.

Mr Packman was a 67 year old man with obesity impairing his mobility, swelling of his legs and leg ulcers admitted to the Queen Alexander Hospital because of cellulitis (infection of the skin) affecting his left leg and groin. He also had pressure sores over his buttocks and thighs. He improved with treatment with antibiotics. He passed loose black stools, suggestive of melaena (blood in the stool) on a couple of occasions, but his haemoglobin was stable, excluding a significant gastrointestinal bleed. He was transferred to Dryad Ward for rehabilitation.

During his admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal; there was a lack of clear, accurate and contemporaneous patient records, inadequate assessment of Mr Packman's condition; a lack of consultation with colleagues and the use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs.

Mr Packman became acutely unwell on the 26th August 1999. A blood test revealed a large drop in his haemoglobin which made a significant gastrointestinal bleed likely. This is a serious and life-threatening medical emergency which requires urgent and appropriate medical care. The commonest underlying cause, a peptic ulcer, can however, be cured. Mr Packman should have been transferred without delay to the acute hospital. However, Mr Packman was not transferred; the blood test result was not obtained or acted upon and he went on to receive doses of diamorphine and midazolam which were not obviously justified and likely to have been excessive to his needs.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mr Packman by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mr Packman by failing to adequately assess his condition and taking suitable and prompt action when he became unwell with a gastrointestinal bleed. He was not appropriately assessed, resuscitated with

fluids, transferred or discussed with the on-call medical team. The use of regular morphine and subsequent use of diamorphine and midazolam in doses likely to be excessive to Mr Packman's needs were inappropriate.

It is the inappropriate management of Mr Packman's gastrointestinal haemorrhage together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam that contributed more than minimally, negligibly or trivially to his death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

Geriatric expert.

Mr Geoffrey Packman was a 68 year old gentleman with a number of chronic problems, in particular, gross (morbid) obesity. He is known to have had leg ulcers and is admitted with a common complication of severe cellulitis. His immobility and infection leads to significant and serious pressure sores in hospital. He develops a probable gastric or duodenal ulcer (again common in patients who are seriously ill), which continues to bleed slowly, then has a massive gastro-intestinal haemorrhage in the Gosport War Memorial Hospital which is eventually the cause of death.

There are a number of weaknesses in the clinical care provided to Mr Packman.

Gastro-intestinal haemorrhage is suspected in Portsmouth, but although never disproven he is continued on his anticoagulant.

Despite the high risks being identified at admission, he does develop pressure sores rapidly during his admission in Portsmouth.

On assessment on 25th August 1999 a further bleed does not lead to medical attention.

On 26th August when he is identified as seriously ill, examination is either not undertaken or recorded in the notes and an investigation which is performed is never looked at or commented on. Gosport War Memorial Hospital also has communication difficulties as the laboratory simply cannot contact the hospital.

A difficult clinical decision is made without appropriate involvement of senior medical opinion.

Prescribing management and use of drug charts by both the nursing and clinical staff, in particular for controlled drugs, is unacceptably poor. A higher than conventional starting dose of Diamorphine is used without any justification for that dose being made in the notes.

Despite all of the above it is the experts opinion that Mr Packman died of natural causes and these deficiencies probably made very little difference to the eventual outcome.

10. Ruby LAKE.

Palliative expert.

Mrs Ruby Lake was a frail 84 year old who was admitted to hospital having fallen and fractured her left hip on 5th August 1998. This was surgically repaired and she had a difficult post-operative course due to events associated with her pre-existing heart and kidney problems, leading to heart failure, atrial fibrillation and renal impairment, along with a chest infection and episodic confusion/agitation at night.

A combination of fluids, diuretics and antibiotics were required to support her through this period. At the time of Dr Lord's review, she summarised Mrs Lake as frail and quite unwell and was uncertain as to whether there would be significant improvement. Subsequent to Dr Lord's review, Mrs Lake experienced chest pains that appeared either related to her ischaemic heart disease or were musculoskeletal in origin, for which GTN (an anti-anginal treatment) or codeine/paracetamol were effective respectively.

Apart from these episodes of pain, Mrs Lake appeared to be progressing rather than deteriorating whilst awaiting transfer to Gosport War Memorial Hospital and had begun to mobilise. On the day prior to transfer, for a period of time, she was noted to appear confused and had a temperature. However, on the day of the transfer she was reported to be well, comfortable and happy with a normal temperature.

Infrequent entries in the medical notes during her stay on Dryad Ward make it difficult to closely follow Mrs Lake's progress over the last three days of her life. She apparently settled in well, but the next day complained of chest pain.

A syringe driver containing diamorphine and midazolam was commenced later that day. Mrs Lake became drowsy, her chest bubbly and the doses of drugs in the syringe driver were modified over the next two days to diamorphine 60mg, midazolam 60mg and hyoscine hydrobromide 800microgram/24h.

Mrs Lake was confirmed dead at 18.25h on the 21st August, the cause of death stated as bronchopneumonmia.

Dr Barton does not appear to have provided Mrs Lake a good standard of clinical care as defined by the GMC; Mrs Lake was not adequately medically assessed by Dr Barton at the time of her transfer or after her complaints of chest pain; there was no justification given for the prescription of morphine or the drugs administered in the syringe driver.
A lack of documentation makes it difficult to understand why Mrs Lake may have deteriorated in the rapid way that she did. A rapid deterioration often suggests an acute underlying medical cause. In this regard, a thorough medical assessment when she complained of chest pain (or indeed at the time of her transfer) may have identified possible contributing factors, such as a chest infection, that could have been appropriately treated. It is therefore

possible that her physical state had deteriorated in a temporary or reversible way and that with appropriate medical care she would have recovered.

If it were that Mrs Lake had naturally entered the terminal phase of her life, at best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mrs Lake a peaceful death, albeit with what appears to be an inappropriate use of medication due to a lack of sufficient knowledge. However, given the lack of medical and nursing records to the contrary, reasonable doubt exists that Mrs Lake had definitely entered her terminal stage.

Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lake by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lake by failing to adequately assess her physical state at the time of her transfer and when she complained of chest pain, failing to take suitable and prompt action when necessary and if her physical state had deteriorated in a temporary or reversible way exposing her to the inappropriate use of diamorphine and midazolam in doses that could have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton leaves herself open to the accusation of gross negligence.

Geriatric expert.

Ruby Lake was an 84-year-old lady with a number of chronic diseases, she suffered a fall and a fractured neck of femur in August 1998. She was admitted to hospital and had operative treatment but developed post-operative complications including chest infection, chest pain and confusion at night and subsequently deteriorated and died in the Gosport War Memorial Hospital.

Mrs Lake had a number of chronic diseases prior to her terminal admission following a fractured neck of femur. She had cardiac disease with known atrial fibrillation, aortic sclerosis and heart failure, documented in 1993. She also had not just osteoarthritis but an auto-immune arthritis that was thought variously to be either rheumatoid arthritis or variant auto-immune arthritis (the CREST syndrome). She also had problems as a result of her long-standing varicose swelling of her lower limbs, with many years of unresolved and very painful leg ulcers. Finally she had impaired renal function, developed mild acute renal failure when she was given on occasion, non-steroidal anti-inflammatory drugs.

When she is transferred to the Gosport War Memorial Hospital she is seen by Dr Barton who fails to record a clinical examination, apart from a statement regarding her functional status.

The continuation notes of Dr Barton then mention rehabilitation with a statement about being happy for the nursing staff to confirm death. There are no further medical notes at all and in view of the subsequent changing

clinical condition documented in the nursing cardex on 19th August and that the nurses contacted the doctor this is a poor standard of care. It also makes it very difficult to asses whether appropriate medical management was given to Mrs. Lake.

On admission the regular drugs being prescribed at Haslar were continued but the Paracetamol and Tramadol she had received in the Gosport War Memorial Hospital only a month before were not prescribed, nor was any other milder analgesia such as Paracetamol. The only analgesia written up was Oramorphine on the 'as required' part of the drug prescription. While it is probably appropriate for somebody who might have been having episodes of angina and left ventricular failure while in Gosport to have a Morphine drug available for nurses to give, it is very poor prescribing to write up no other form of analgesia, particularly if a doctor is not on site. The nursing staff could have no alternative but to go straight to a strong opioid analgesia.

On her first night she is documented as anxious and confused. This is then treated by giving a dose of Oramorphine despite there being no record in the medical or nursing cardex that it was pain causing this confusion. It should be noted this was probably no different from her evenings in Haslar which did not need any specific medication management. It is the experts view that this is poor nursing and medical care in the management of confusion in the evening.

On 19th August an event happened at 11.50 in the morning with the nursing notes recording that she had marked chest pain and was grey around her mouth. This could have been a heart attack, it could have been a pulmonary embolus, it could have been another episode of angina, it could simply have been some non-specific chest pain. No investigations are put in train to make a diagnosis, she does not appear to have been medically assessed, or if she was it was not recorded in the notes and would be poor medical practice. However, if the patient was seriously distressed, it would have been appropriate to have given the Oramorphine 10 mgs that was written up on the 'as required' side of the drug chart. The first aim would be to relieve distress while a diagnosis was made.

Later on 19th August a syringe driver is started containing Diamorphine 20 mgs and 20 mgs of Midazolam. The only justification for this is recorded in the nursing notes where it says pain is relieved for a short period. I am unable to find any records of observations, for example, pulse or blood pressure while the patient continues to have pain.

The syringe driver is continued the next day and Hyoscine is add and the dose of Diamorphine, Midazolam and Hyoscine all increase during the afternoon of the 20th and again when the syringe driver is replaced on 21st. Mrs Lake dies peacefully on 21st August.

Diamorphine is specifically prescribed for pain, is commonly used for pain in cardiac disease as well as in terminal care. Diamorphine is compatible

with Midazolam and can be mixed in the same syringe driver and is widely used subcutaneously as doses from 5 – 80 mgs per 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 20 mgs for the first 24 hours, which is within current guidance.

The original dose of Diamorphine appeared to be for continued chest pain. It is unusual to use continuous Diamorphine for chest pain without making a specific diagnosis. It is possible the patient had had a myocardial infarction and was now in cardiogenic shock. In that case it would be very reasonable to use a syringe driver and indeed to add Midazolam and Hyoscine over the subsequent 48 hours. This can only be supposition without adequate documentation.

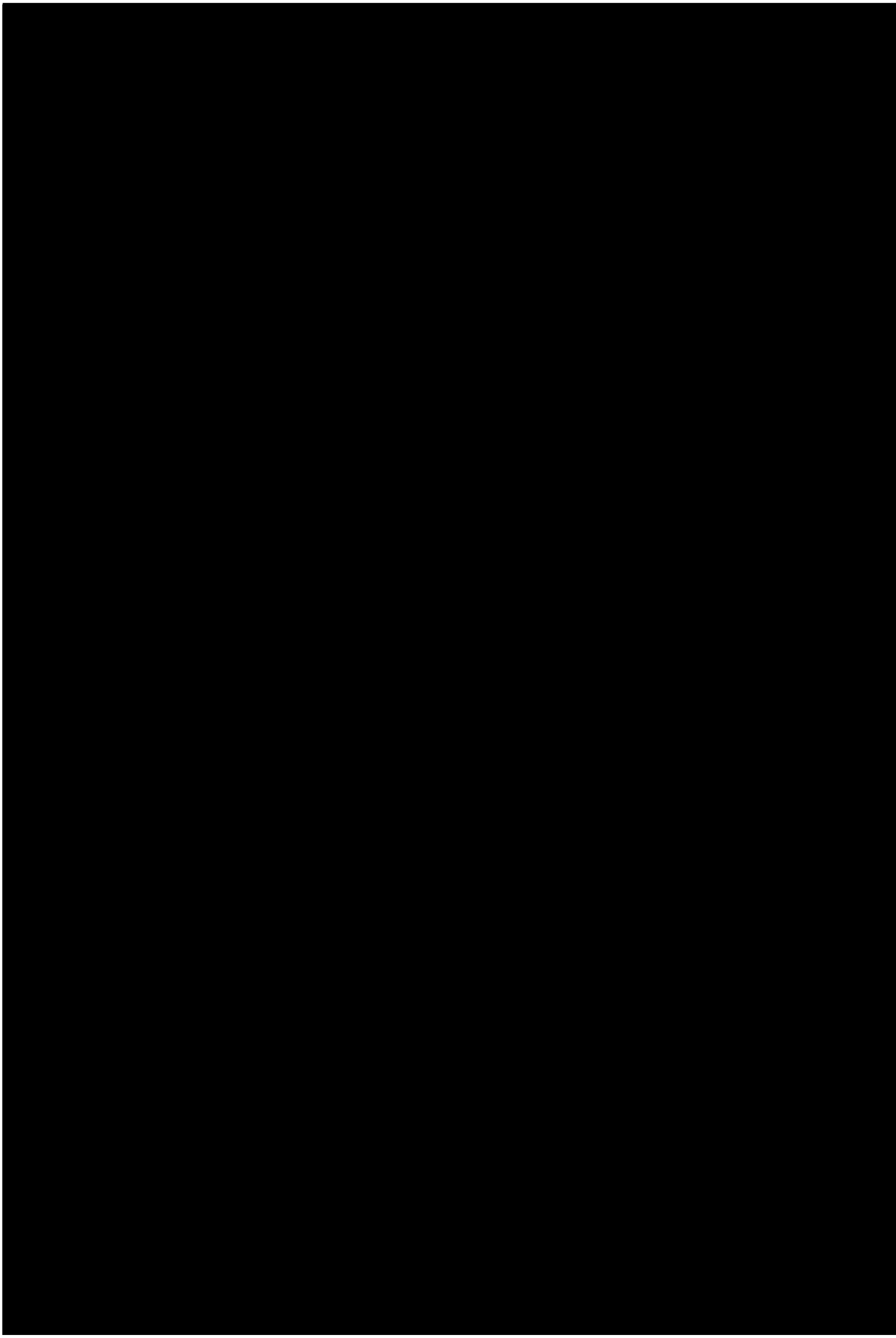
It is impossible from the notes to determine the cause of death and a Coroner's Post Mortem should have been held.

The combination of a lack of a documented clinical examination, the lack of prescription of appropriate oral analgesia on admission to Gosport, the decision to start a syringe driver without documentation of a clinical diagnosis or the reason for it in the medical notes, together represent a negligent standard of medical care.

Without a proven diagnosis, it is possible that the combination of Diamorphine and Midazolam together with the Hyoscine in a syringe driver contributed in part to Mrs Lake's death. However the expert unable to satisfy himself to the standard of beyond reasonable doubt that it made more than a minimal contribution.

Summary prepared from medical evidence received to date.

D.M.Williams Det Supt
Senior Investigating Officer.
6th June 2006.



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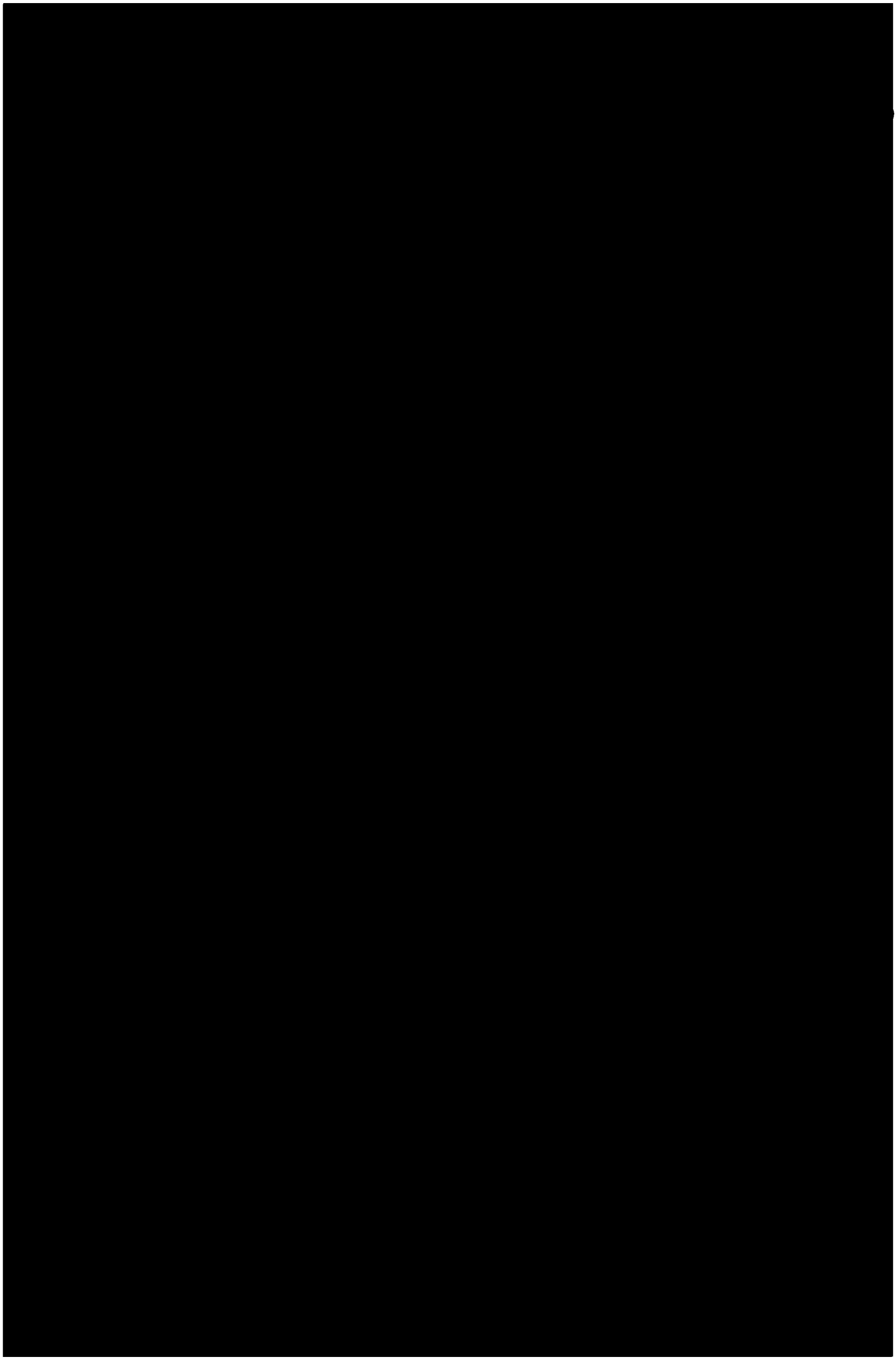

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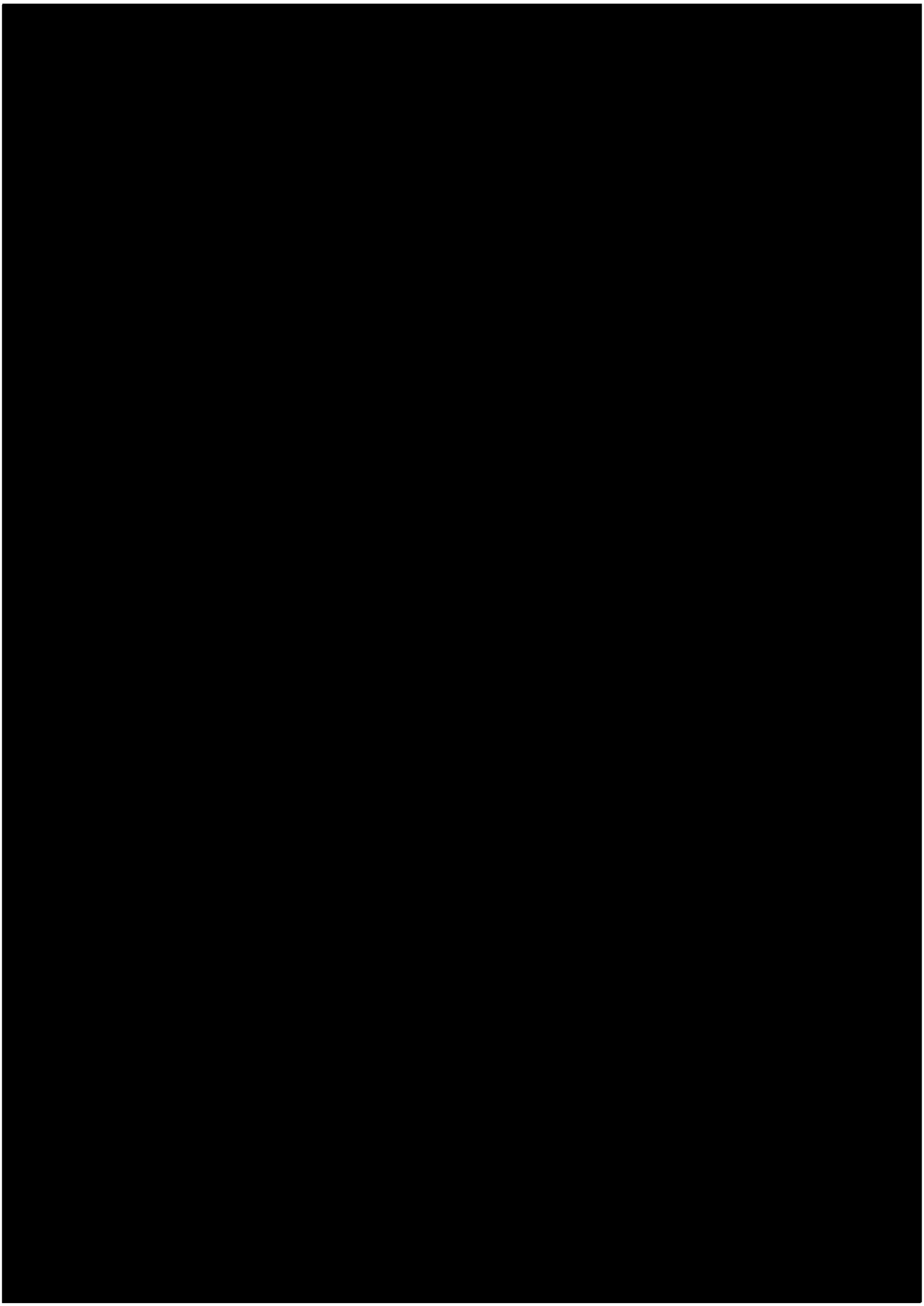

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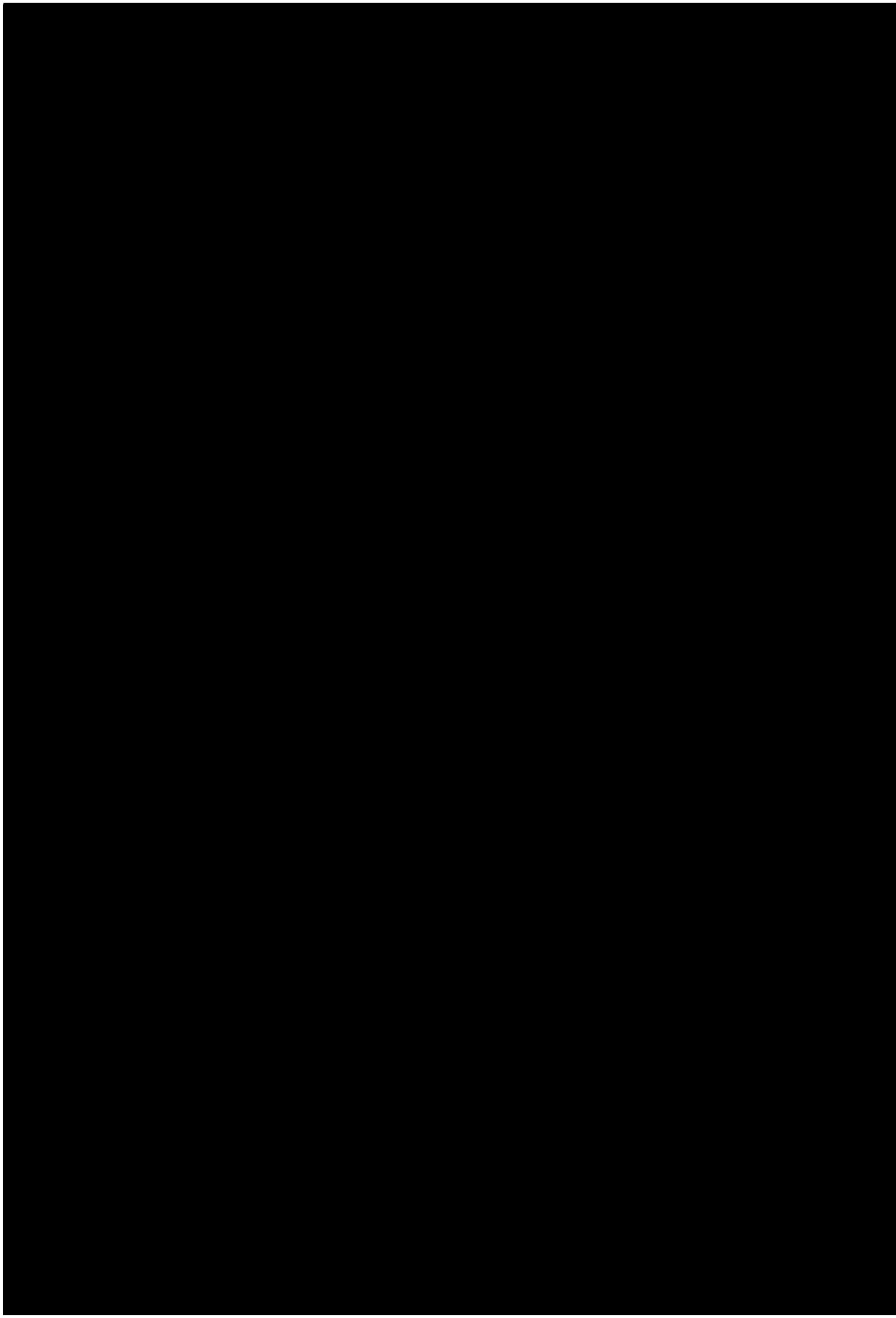

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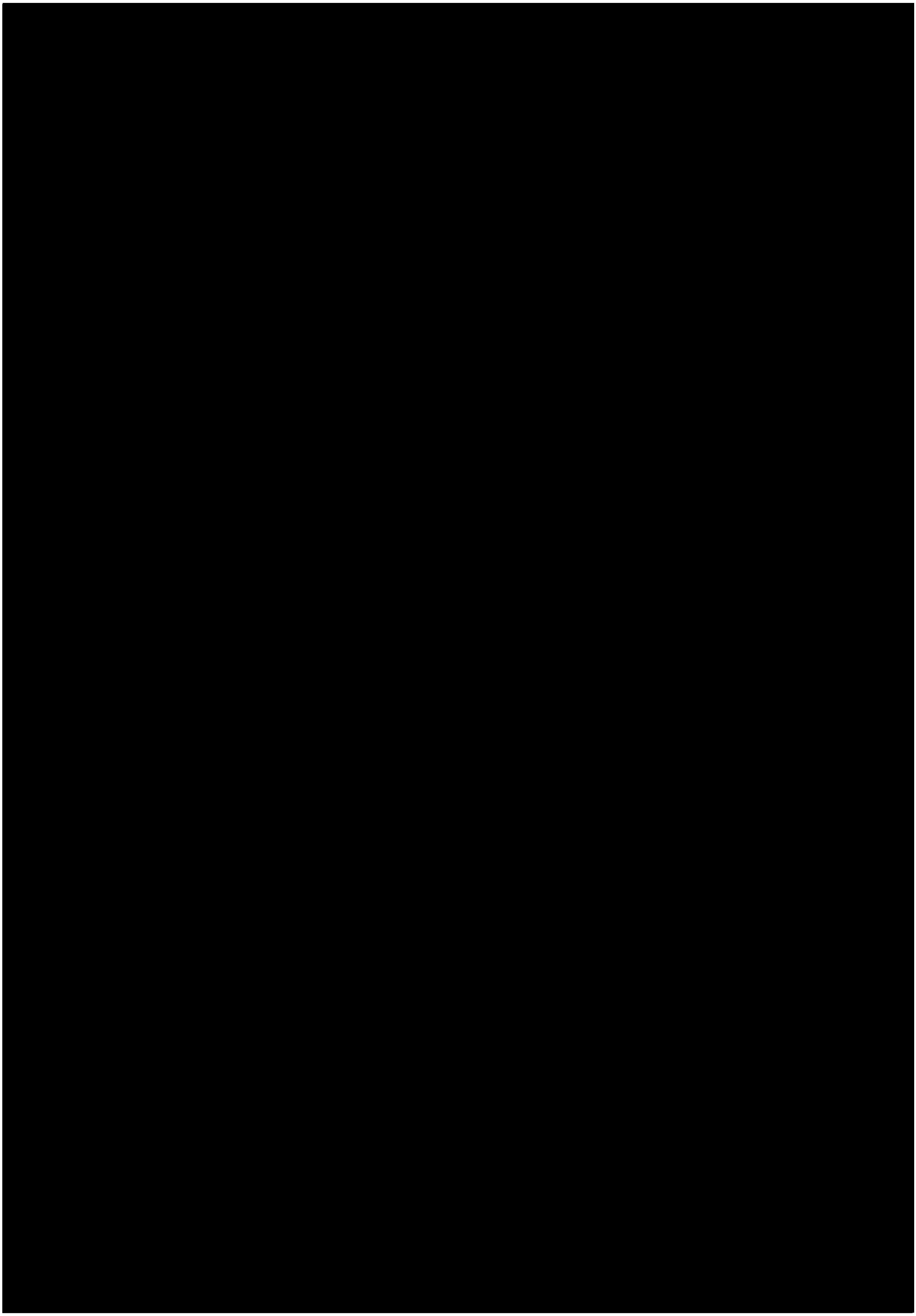

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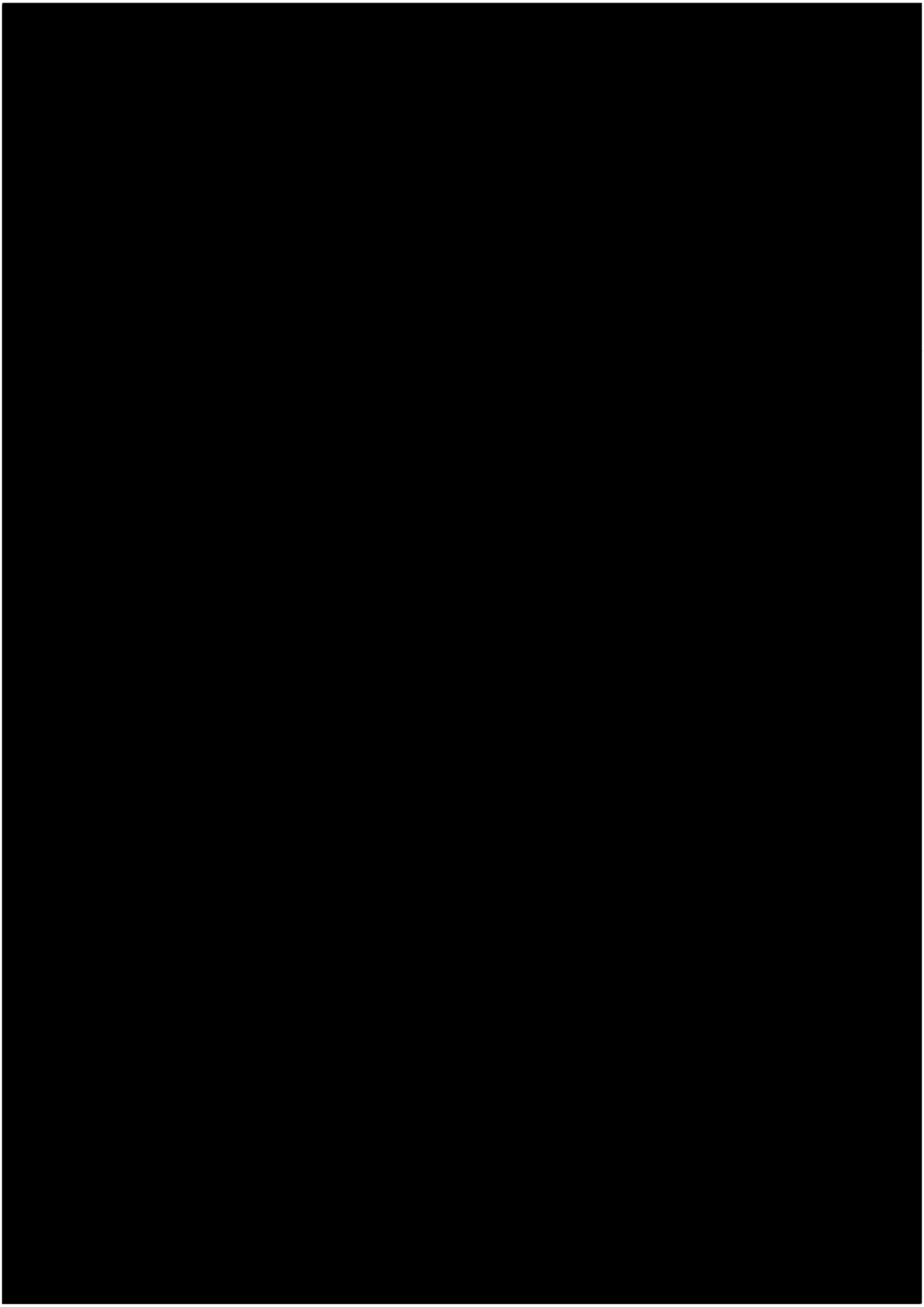

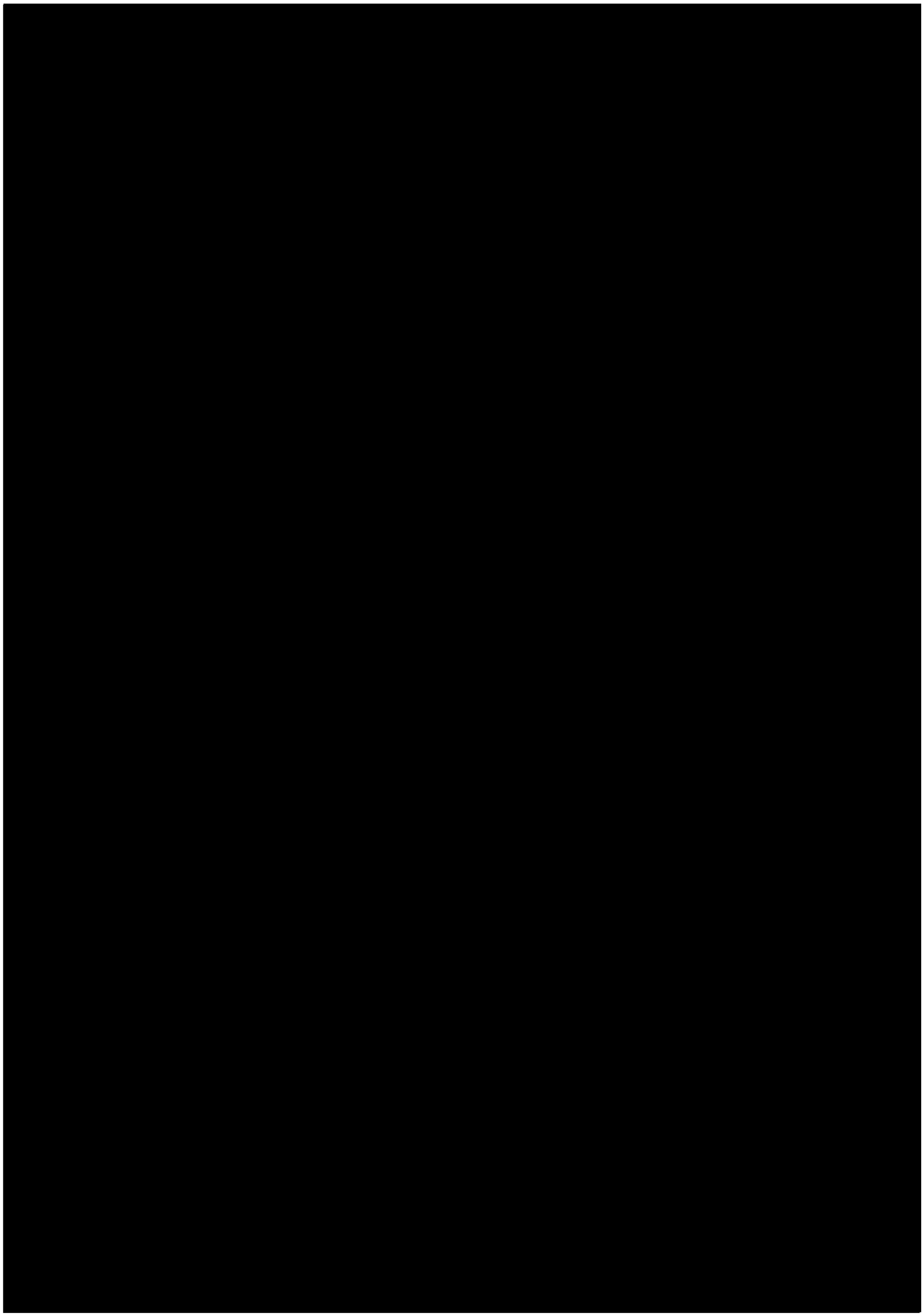

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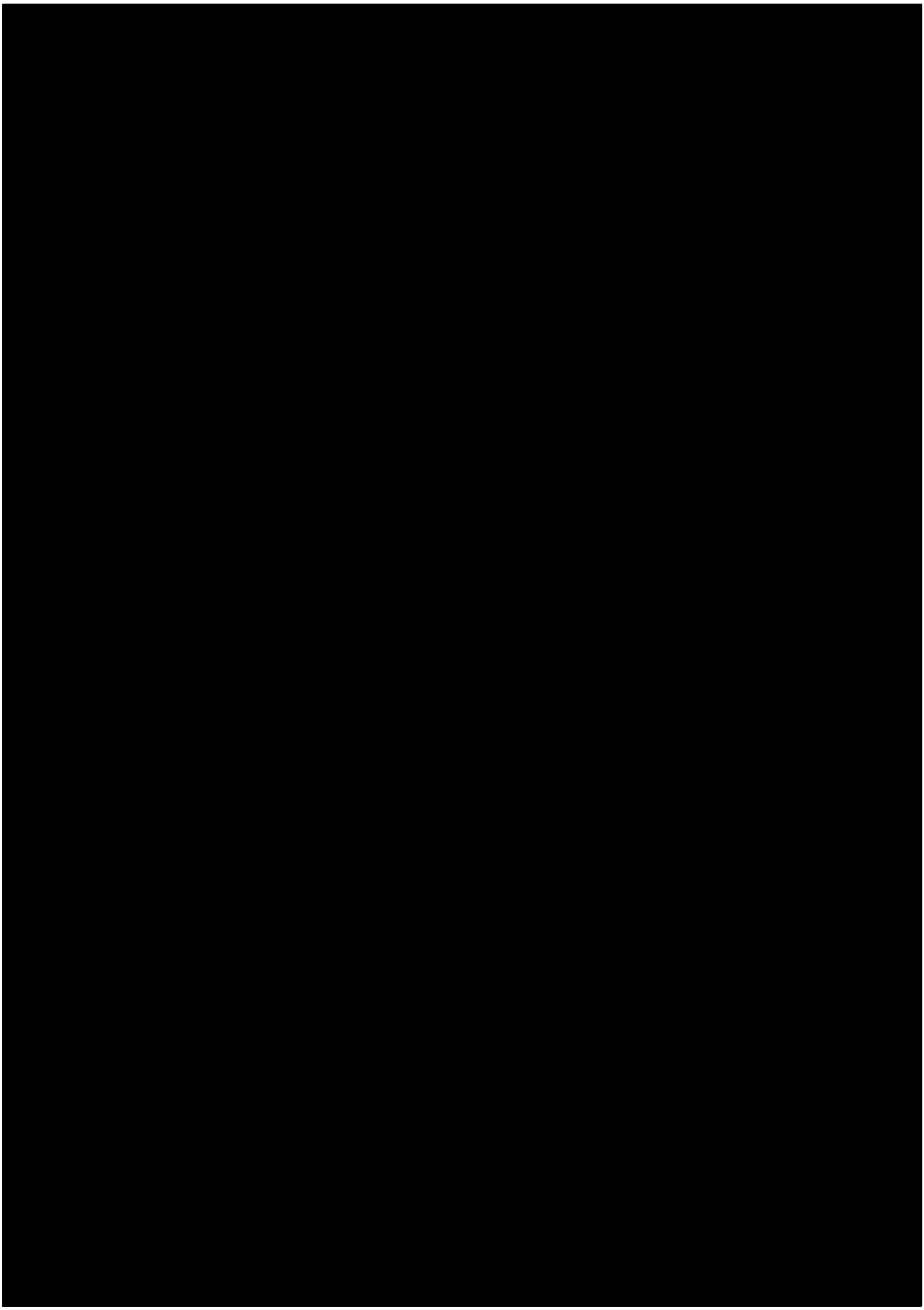

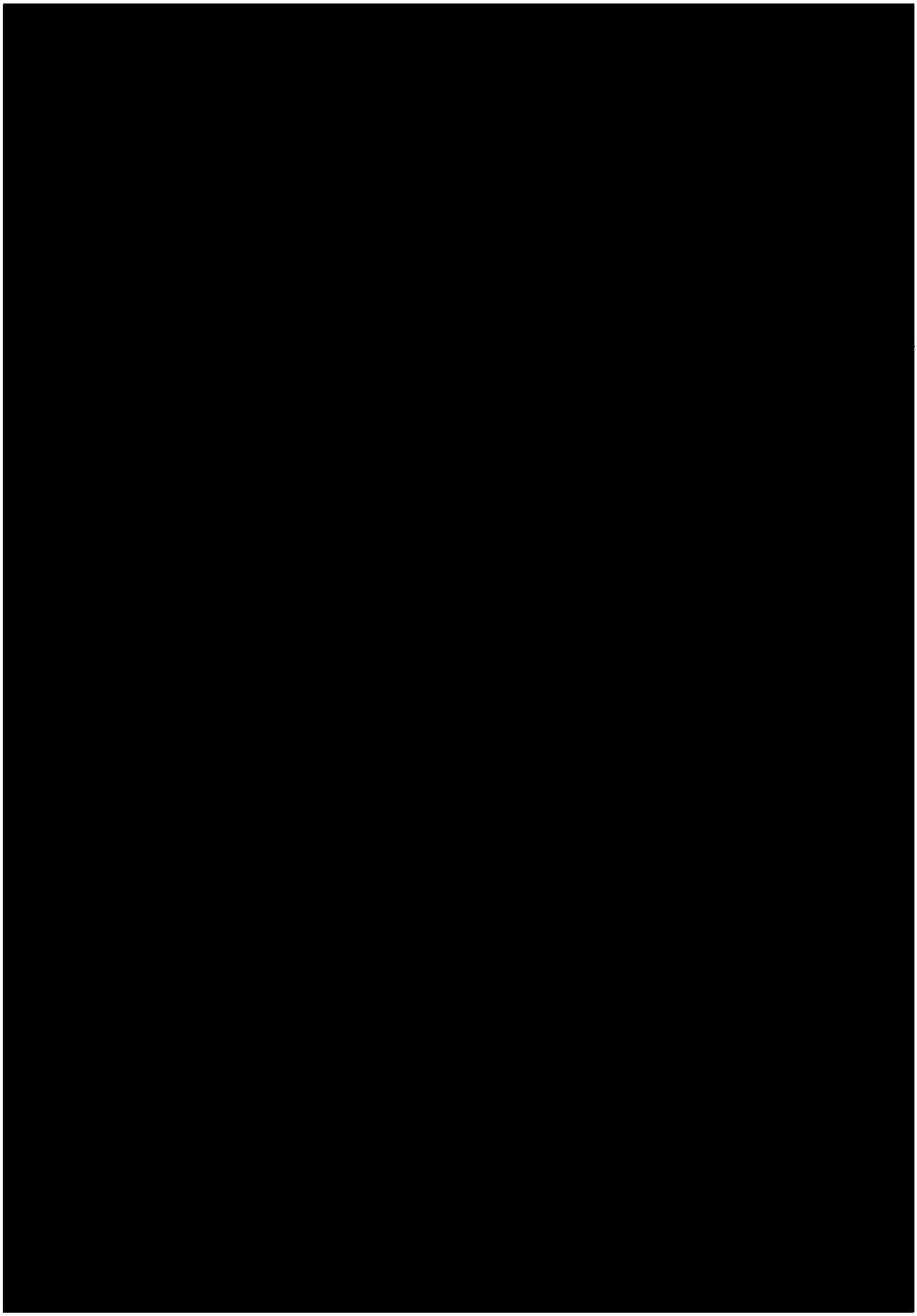

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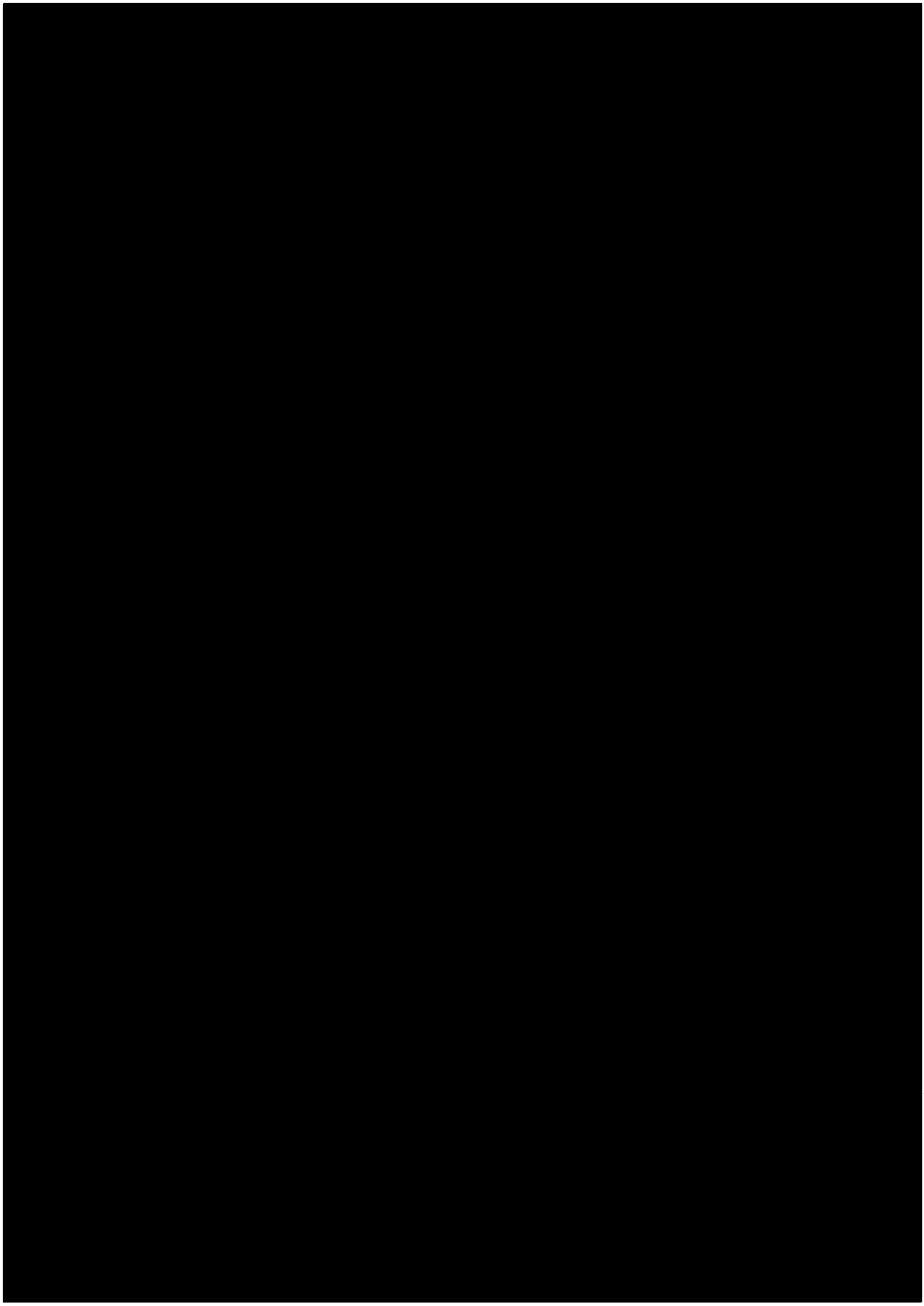

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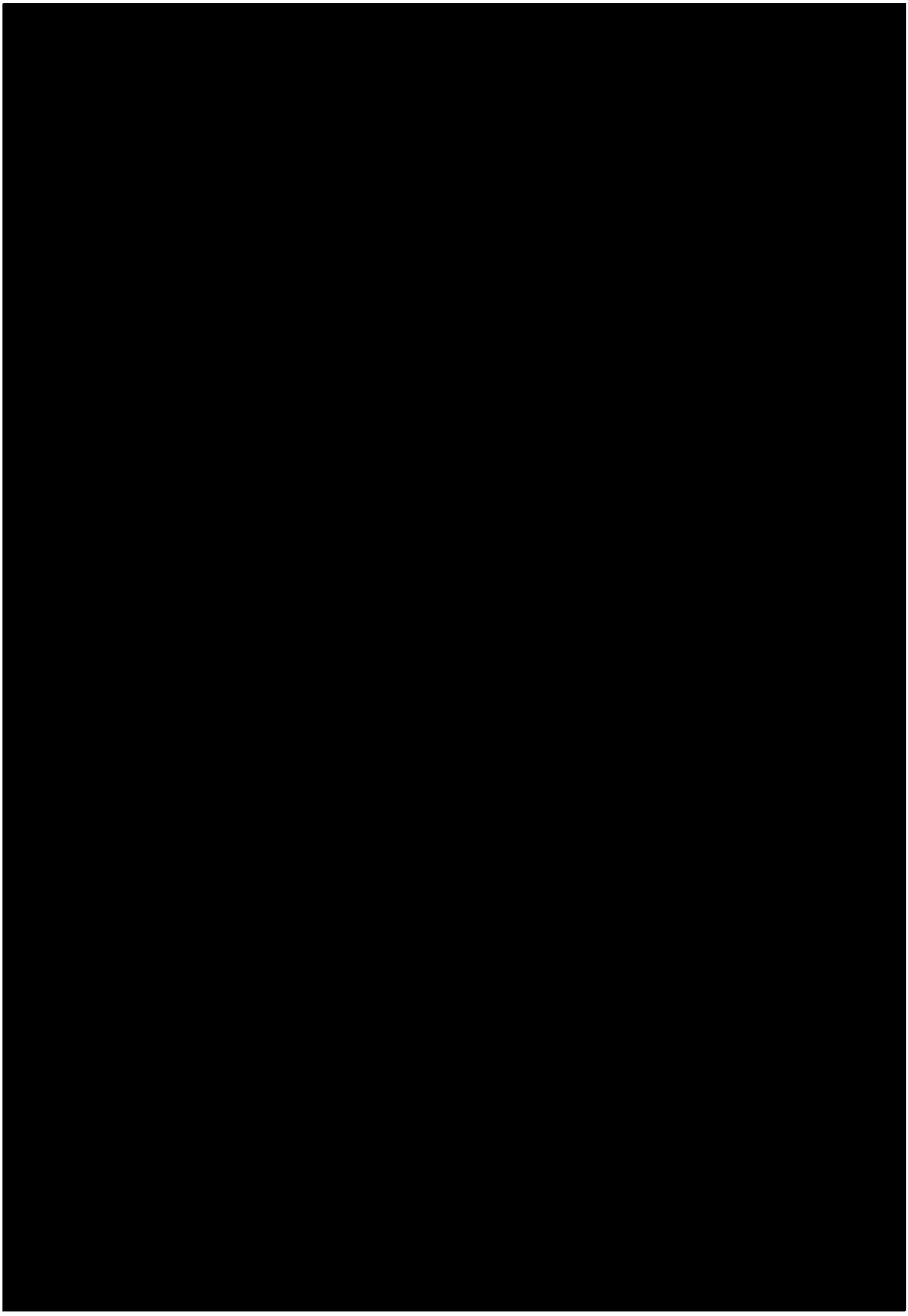

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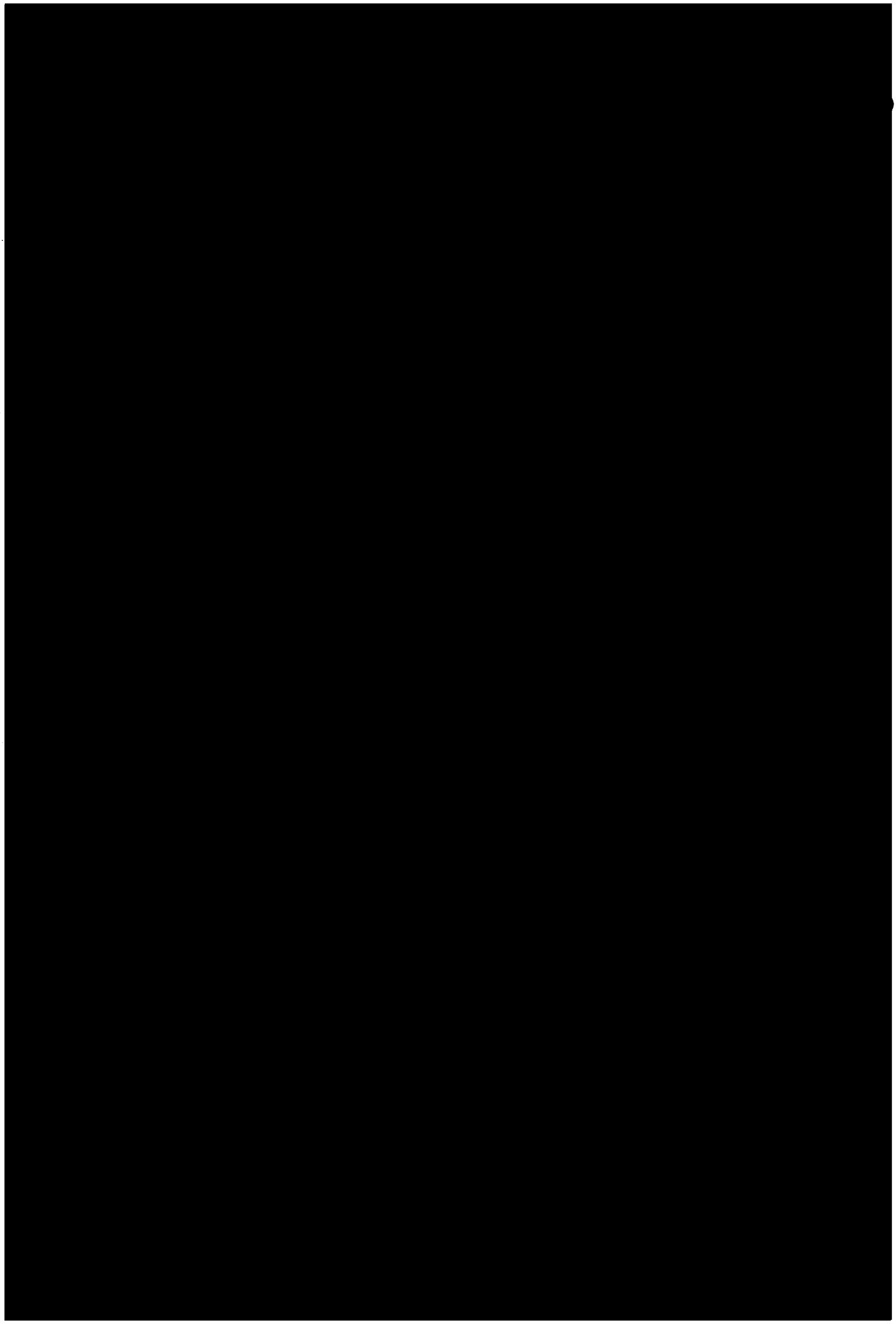

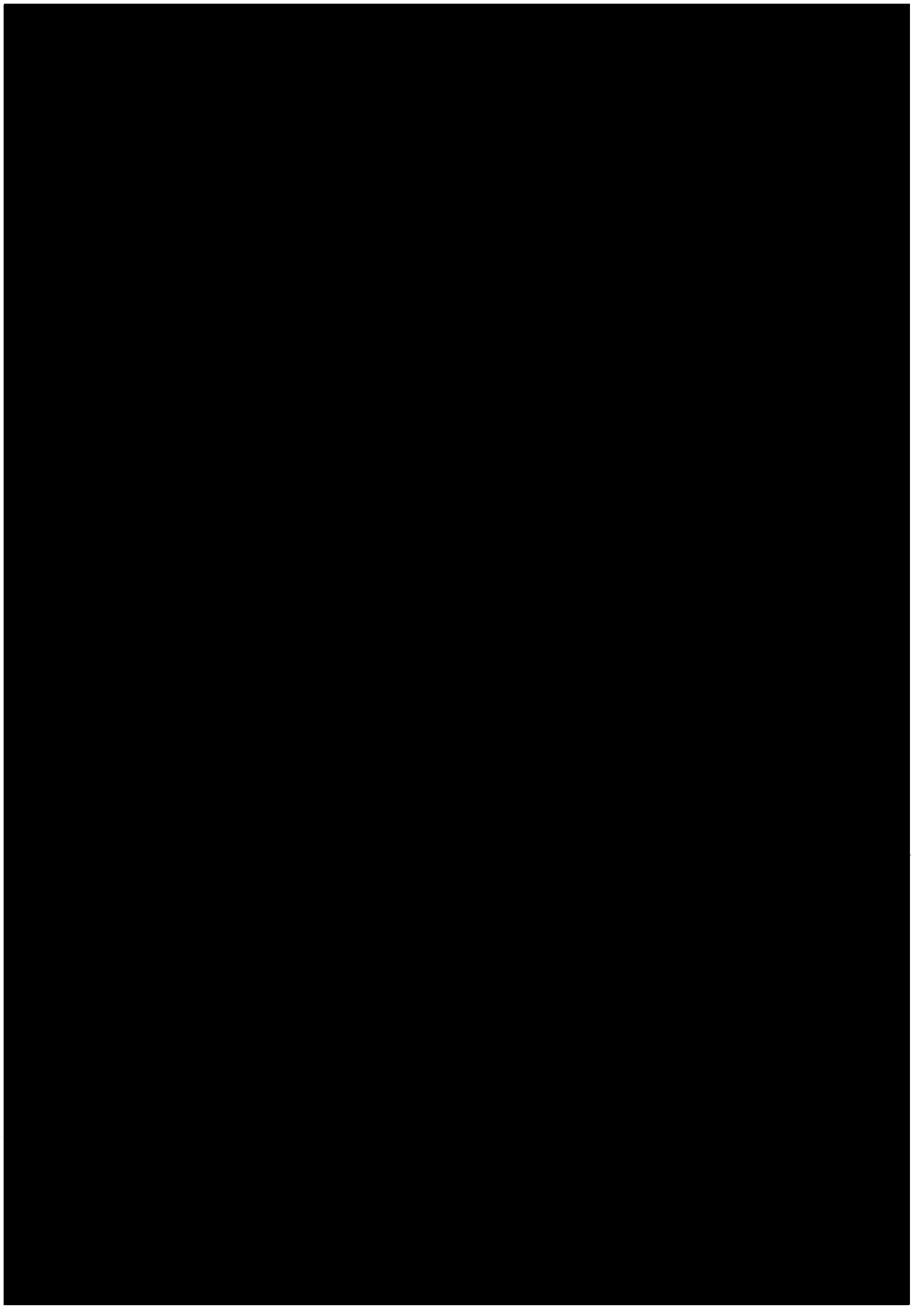

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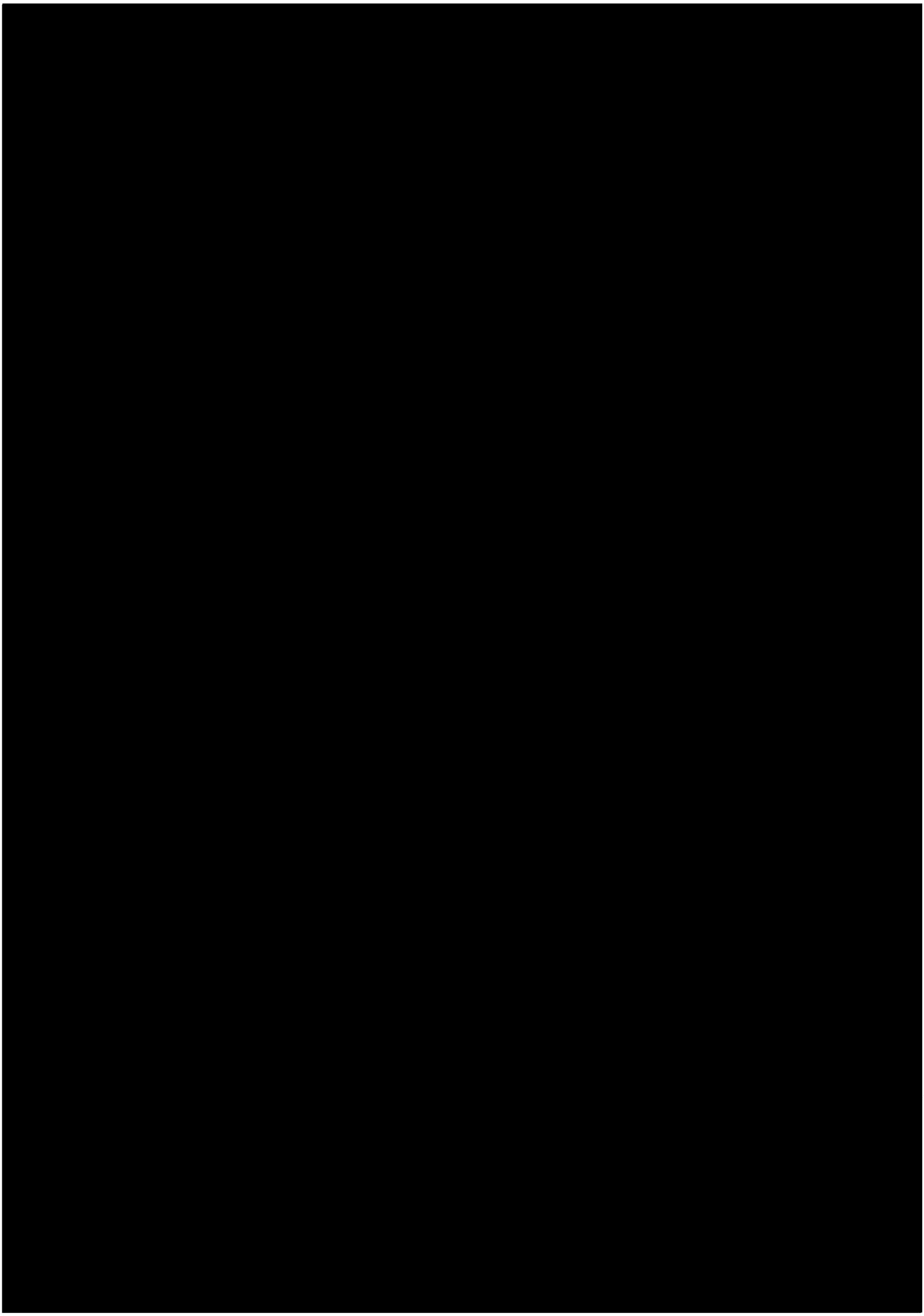

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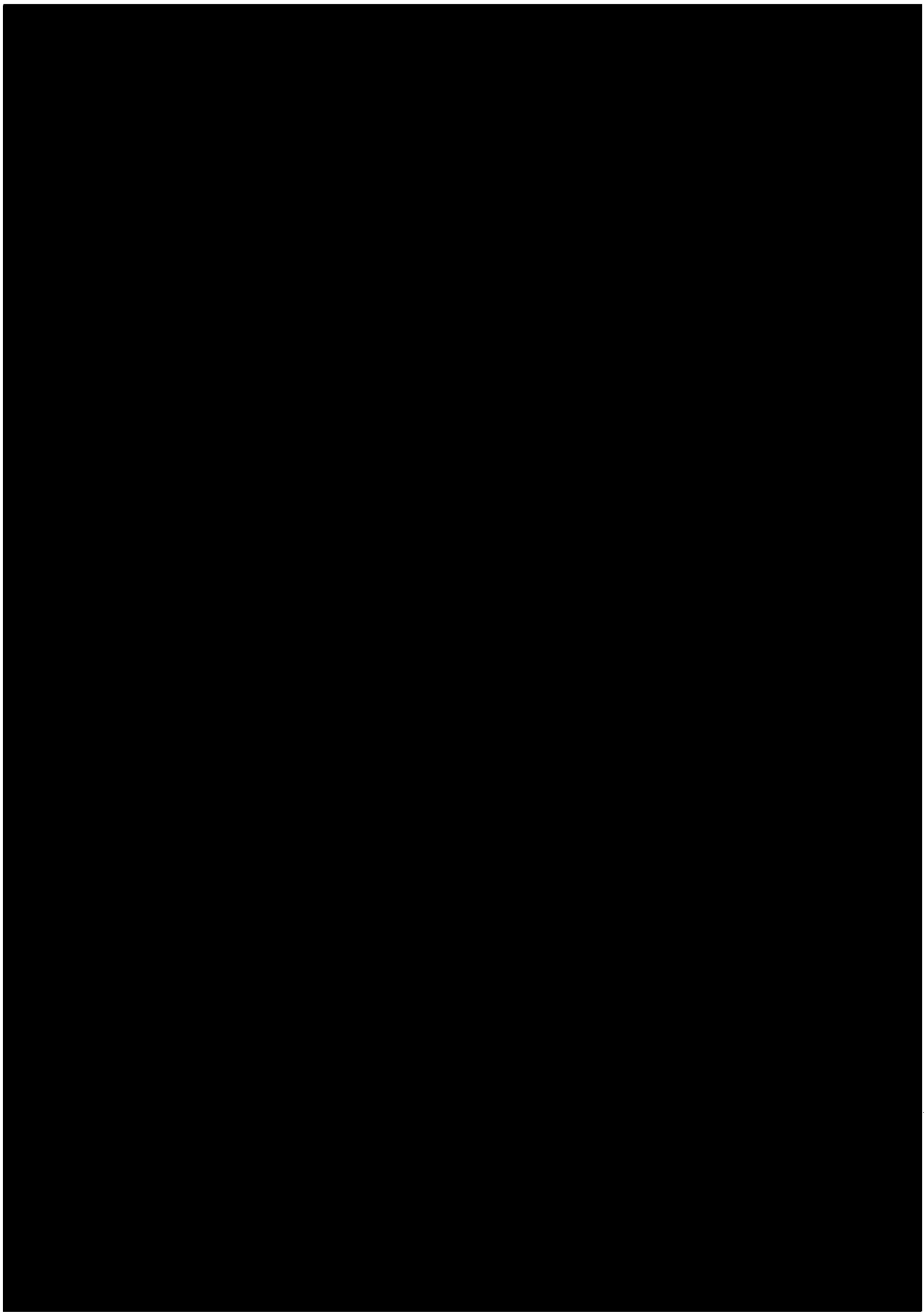

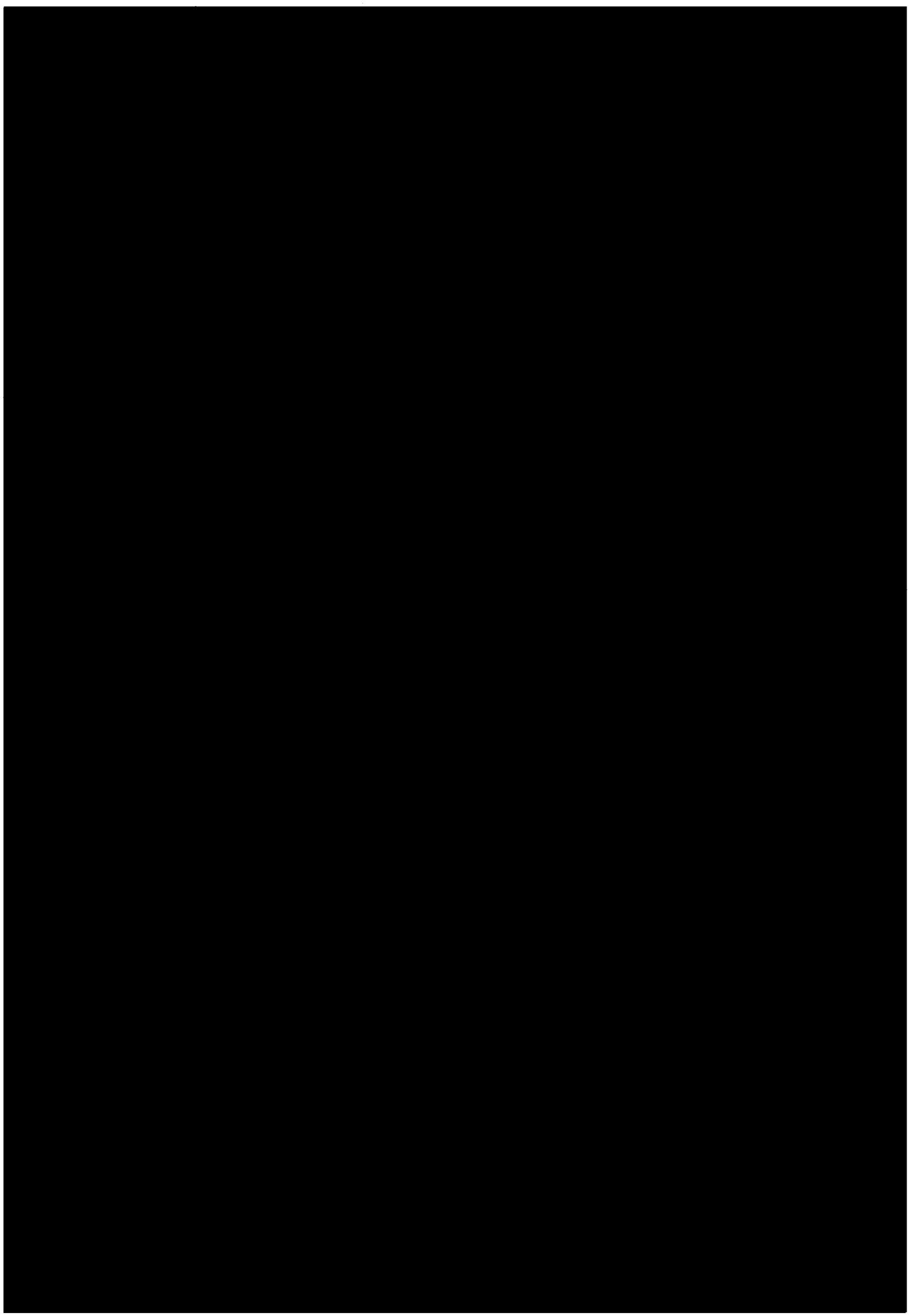

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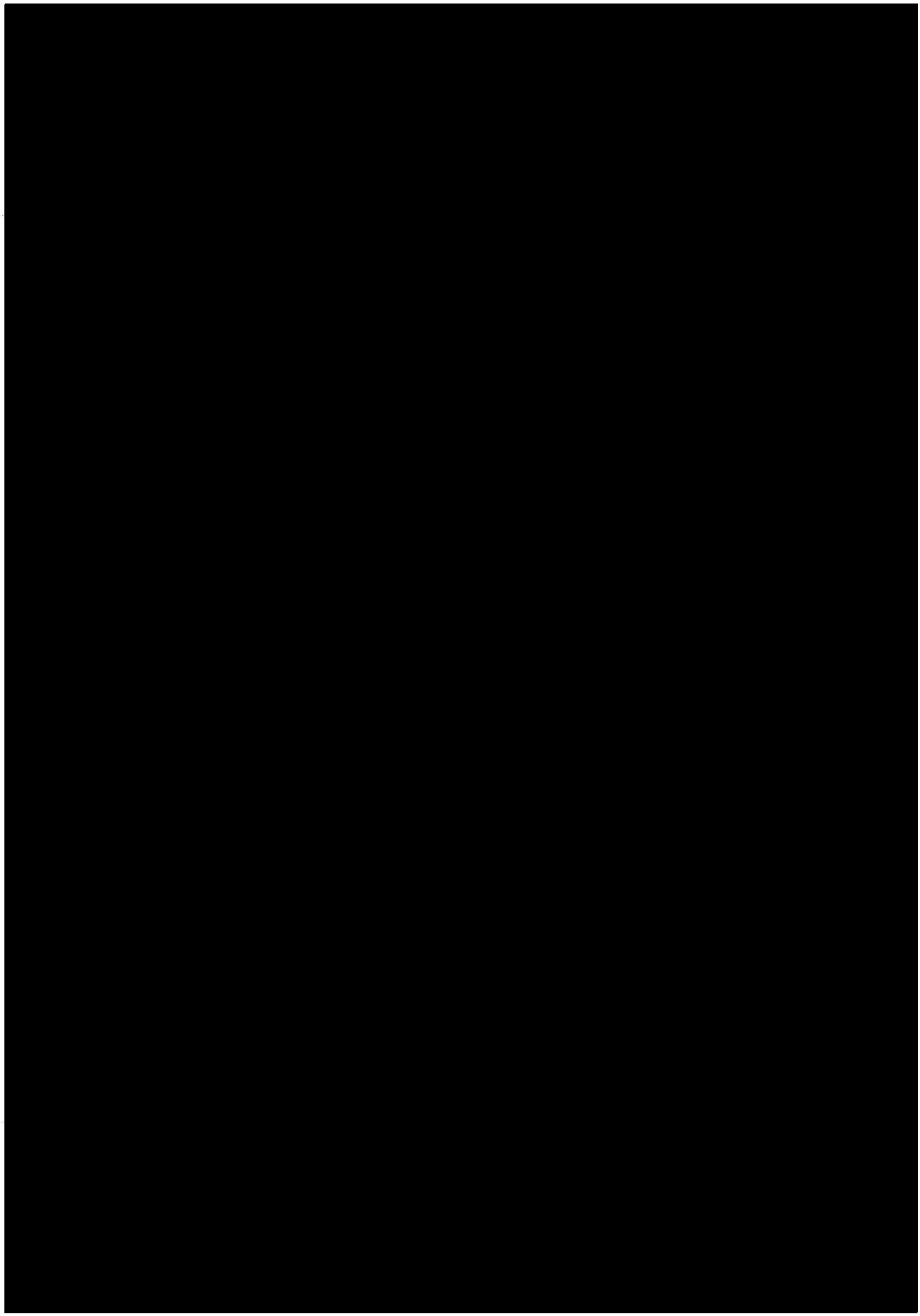

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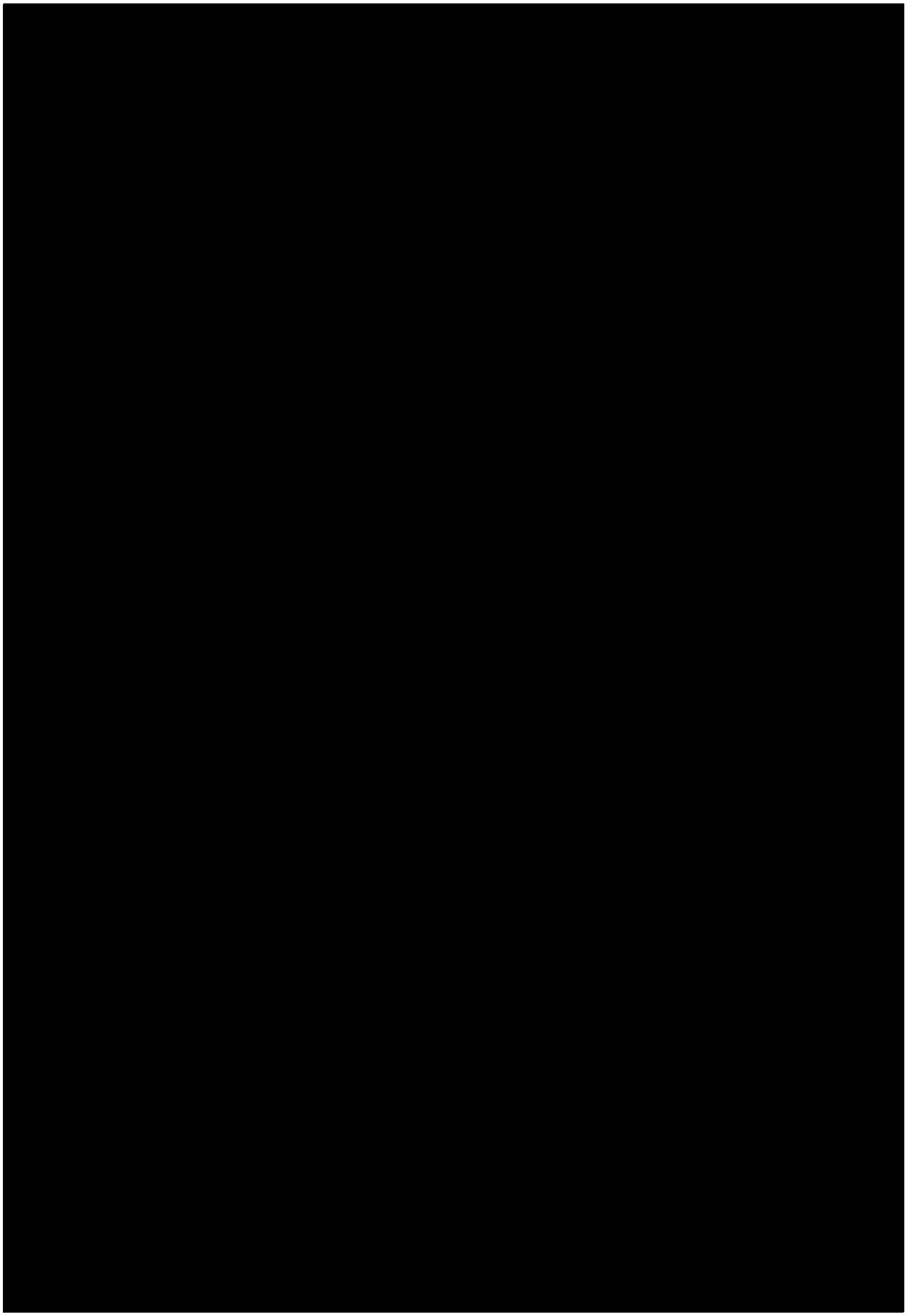

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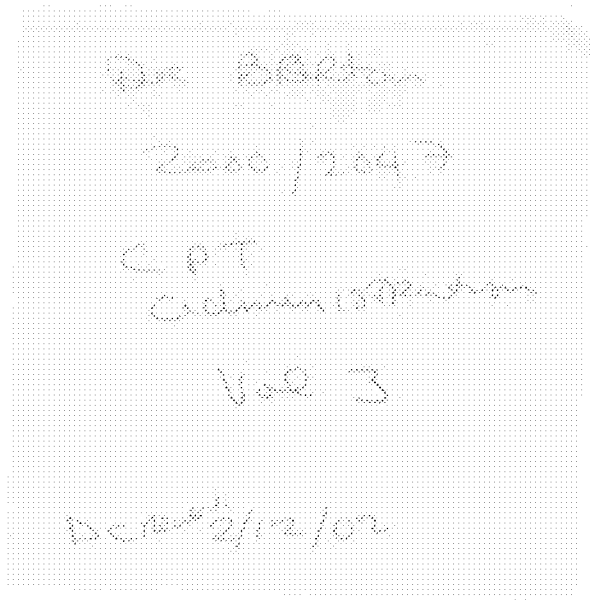
A Review of Deaths of Patients

at

Gosport War Memorial Hospital



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A Review of Deaths of Patients

at

Gosport War Memorial Hospital

Final version: October 2003

Contents

Acknowledgements

The staff of the records department of Gosport War Memorial Hospital have provided considerable assistance in identifying and obtaining documents for the review, and I am grateful to them for their assistance. I also thank Peter Goldblatt of National Statistics and Stephen Price of Hospital Episode Statistics, and Professor Code A of the Department of Epidemiology and Public Health, University of Leicester, for advice and for undertaking the analysis of the relationship between numbers of deaths and periods of leave. I also acknowledge the assistance of Paul Sinfield, research associate, in management of the databases required for the review, and Ms Vicki Cluley for assistance in preparation of the manuscript.

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Summary

This report presents the findings of an audit of care at Gosport War Memorial Hospital that was commissioned by the Chief Medical Officer. Concerns about the care of patients in Gosport hospital were first raised in 1998, and a police investigation is continuing.

The audit has drawn on documentary evidence that has included:

1. A random sample of 81 clinical records of patients who died in Gosport hospital between 1988 and 2000
2. The counterfoils of medical certificates of the cause of death (MCCDs) retained at Gosport hospital relating to deaths in the hospital 1987-2001
3. The admissions books of Dryad ward at Gosport, 1993-2001
4. Surviving controlled drugs registers at Gosport hospital
5. MCCDs completed by a sample of general practitioners in Gosport.

On the basis of these sources of evidence, I have concluded that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that a small number of these would otherwise have been eventually discharged from hospital alive.

The practice was disclosed in several key findings.

- Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver.
- Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia, and strokes.
- Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later.
- In many records, evidence of a careful assessment before use of opiates was absent, and the stepped approach to management of pain in palliative care had not been followed.

In addition to these findings, two other matters also gave rise to concern. The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths, most commonly fractured hips, had not been reported on MCCDs.

Most patients admitted to Gosport under the care of the Department of Medicine for Elderly People had severe clinical problems, and many had been transferred from acute hospitals after prolonged in-patient stays. Some had been admitted for rehabilitation, but many were believed to be unlikely to improve sufficiently for discharge to a nursing home. Consequently, a relatively high number of deaths among those admitted would have been expected. The types of patients (case mix) admitted to Gosport varied during the period of interest (1988-2000), and it was not possible to identify an adequate source of data about numbers of deaths in similar hospitals that admitted similar types of patients in the same time periods to enable a reliable estimate of excess deaths to be calculated. Nevertheless, the findings tend

to indicate that the finding of a statistical excess of deaths among patients admitted to Gosport would be unlikely.

In undertaking the audit, I have drawn on documentary evidence only. There has been no opportunity for relatives or staff involved in the care of patients in Gosport to give information or comment on the findings. Dr Barton in particular has not been invited to give a first hand account of care at Gosport or comment on the findings of the review. It is possible, therefore, that my conclusions would be altered in the light of information from Dr Barton or other individuals. However, such information would be more appropriately considered in a different type of inquiry, for example that being undertaken by the police, rather than in the context of an audit.

Recommendations

In view of the findings of the audit, I submit the following recommendations:

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.
4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to

suspect that some patients at the end of life do not receive adequate analgesia.

5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

Chapter One: Introduction

This report describes a review of the deaths of older patients at Gosport War Memorial Hospital. The review was commissioned by the Chief Medical Officer because concerns had been raised about the care of some elderly patients who had died in the hospital, and is particularly concerned with the deaths of elderly patients under the care of the Department of Medicine for Elderly People.

Gosport War Memorial Hospital is a 113-bed local hospital situated on the Gosport peninsula. It was part of Portsmouth Health Care NHS Trust from April 1994 until April 2002, when the services at the hospital were transferred to the local primary care trusts (Fareham and Gosport PCT, and East Hampshire PCT). Gosport itself is a relatively isolated community at the end of a peninsula with some areas of high deprivation. It is reported to be under-provided with nursing homes

Concerns about deaths at the hospital were raised in September 1998, when police commenced investigations into an allegation that a patient had been unlawfully killed on Daedalus ward. In March 1999, the Crown Prosecution Service (CPS) decided that there was insufficient evidence to prosecute. In 2001, a further police investigation took place, and again the CPS decided that there was insufficient evidence to proceed. In January 2000 an NHS Independent Review Panel found that whilst drug doses were high, they were appropriate in the circumstances.

A complaint was made to the Health Service Commissioner against Portsmouth Healthcare NHS Trust about the death of a patient who had undergone an operation on a broken hip at another hospital and had been transferred in October 1998 to Gosport War Memorial Hospital 1998. The patient had died of bronchopneumonia in

December 1998, and the complaint was that the patient had received excessive doses of morphine, had not received reasonable medical and nursing care, and had been allowed to become dehydrated. The Commissioner undertook an investigation, at the conclusion of which he accepted professional advice that medical management had been appropriate and that the patient's nursing needs had been systematically assessed and met. The pain relief was judged to have been appropriate and necessary for the patient's comfort and the commissioner did not uphold the complaint.

In March 2001, 11 families raised further concerns with the police about the care and deaths of relatives in 1998, and four of these deaths were referred for an expert opinion. In August 2001, the police shared their concerns with the Commission for Health Improvement (CHI), and CHI then began an investigation.

The CHI Review (2001-2002)

The terms of reference of the review are shown in Box 1.1., and indicate that the aim of the review was to investigate care since 1998 rather than to undertake an investigation into care at the hospital leading up to the complaint first raised in 1998. During the review, CHI studied documents held by the trust, received views from samples of patients, relatives and friends, conducted a five-day site visit during which 59 staff from all groups involved in the care of elderly patients were interviewed, undertook an independent review of the notes of a sample of patients who had died on three wards (Daedalus, Dryad and Sultan) between August 2001 and January 2002, and interviewed relevant agencies, including those representing patients and relatives. On concluding its review, CHI did commend some features of services at Gosport, including leadership in Portsmouth Healthcare NHS Trust, the

standard of nursing care on Daedalus, Dryad and Sultan wards, and the trust's clinical governance framework. However, CHI also reported several concerns (Box 1.2.).

Box 1.1. Terms of reference of the CHI review (CHI, 2002).

The 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 services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i) staffing and accountability arrangements, including out of hours

ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management

iii) arrangements for the prescription, administration, review and recording of drugs

iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations

v) arrangements to support patients and their relatives and carers towards the end of the patient's life

vi) supervision and training arrangements in place to enable staff to provide effective care.

In addition, CHI will examine how lessons to improve patient care have been learnt across the trust from patient complaints.

The investigation will also look at the adequacy of the trust's clinical governance arrangements to support inpatient continuing and rehabilitation care for older people.

Box 1.2. CHI's key concerns

- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.
- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the 'Wessex guidelines', this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.
- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non-physical symptoms of pain, the trust's policies do not include methods of non-verbal pain assessment and rely on the patient articulating when they are in pain.
- Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- The police investigation, the review of the Health Care Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

CHI did undertake an independent review of anonymised medical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. It should be noted that this was a period in which the clinical assistant no longer worked at the hospital, and in particular excludes deaths during the period 1998-1999, when concerns first arose. The case note review confirmed that the admission criteria for Dryad and Daedalus wards were being adhered to. CHI also investigated the amount of diamorphine, haloperidol and midazolam used on Daedalus and Dryad wards between 1997/1998 and 2000/01. These data indicated a decline in use of diamorphine and haloperidol on both wards after 1998/1999, with a relatively less marked decline in the use of midazolam in the later years.

Staff concerns about the use of diamorphine, 1991-2

Staffs concern about the use of diamorphine was brought to the attention of the branch convenor of the Royal College of Nursing (RCN) in April 1991, the convenor being told that the problem had been present for the past two years. At a specially convened meeting in July 1991, nursing staff of Redclyffe Annexe raised their concerns about the use of diamorphine with the patient care manager of Gosport Hospital. Among the points made at that meeting were that not all patients who had been given diamorphine had pain, no other forms of analgesia had been considered, the drug regime was not always tailored to each patient's individual needs, and that deaths were sometimes hastened unnecessarily. Discussions took place between nursing and medical staff, the patient care manager and the RCN convenor over the ensuring months, with the result that a plan for the use of diamorphine appears to have been agreed.

The role of the clinical assistant, Dr Barton

The concerns, police investigations and GMC referral have focussed on the role of the clinical assistant involved, Dr Jane Barton. Dr Barton is a general practitioner based in a practice in Gosport. She was employed for five sessions a week as a clinical assistant in the Department of Medicine for Elderly People from 1st May 1988 until her resignation on 5th July 2000. In this post, Dr Barton was accountable to the consultant physician in geriatric medicine, and responsible for arranging cover for annual leave and sickness absence with her practice partners. The post was subject to the terms and conditions of hospital, medical and dental staff.

When Dr Barton began work at the hospital, she had responsibility for patients in Redclyffe Annexe. This unit is isolated from the main parts of the hospital, and had

approximately 20 beds classified as continuing care. Until 1993/4, there were also two wards (referred to as the male and female wards) at the main hospital site, having a total of approximately 37 beds (Box 1.3.). Nineteen of these were designated for use by patients under the care of their GP, and seven designated as GP day surgery beds. Dr Barton was responsible for the care of patients in the remaining 11 beds. (The precise number of beds on the female ward is uncertain since the information is based on the memories of staff. It is believed to have been 20 or 21.) The total number of beds under the supervision of Dr Barton was therefore 31 until 1993/4.

From 1993/4, Dr Barton appears to have ceased responsibility for Redclyffe Annexe, and taken on responsibility for Dryad and Daedalus wards in the new hospital building, the male and female wards being closed. This gives a total of 44 beds under Dr Barton's care, with a mix of continuing care and rehabilitation. CHI was critical of arrangements for supervising the practice of the clinical assistant, and found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Some of the staff interviewed had indicated that the clinical assistant worked in excess of the five contracted sessions. The CHI review notes that in 1998, there was a fortnightly consultant ward round on Daedalus ward. Ward rounds were also scheduled fortnightly on Dryad ward, although they occurred less frequently.

Box 1.3 Reported bed use at the hospital

1980-1993:

Northcott house, 11-12 continuing care beds

Redclyffe Annexe 20 continuing care beds

Male ward - 17 beds (9 continuing care, 8 GP beds)

Female ward – 20 beds (2 continuing care, 7 GP day surgery, 11 GP beds)

Total beds 1980-1993=69

From 1994:

Redclyffe Annexe was still used;

Sultan ward – 24 GP beds

Dryad ward – 20 continuing care beds

Daedalus – 24 beds in total (8 slow stream stroke from April 1994. 16 continuing care [24 prior to April 1994]); from 2000, the Daedalus beds were used for intermediate care, comprising 8 fast stream stroke, 8 slow stream stroke, 8 general rehabilitation.

Other investigations

Several other investigations have been, or are being, undertaken into the events at Gosport War Memorial Hospital. Hampshire Constabulary are continuing an intensive investigation, and I am grateful to them for their agreement that the review requested by the Chief Medical Officer should be completed. A referral to the General Medical Council (GMC) has also been made. However, the review described in this report is an independent clinical review or audit. I have sought to come to an

independent view based on an analysis of clinical information from surviving documentary evidence (for example, clinical records, drug registers, medical certificates of the cause of death, and ward registers). The review does not consider statements from witnesses, and does not involve a detailed forensic inquiry into particular deaths, since these aspects are the proper responsibility of the police and other agencies.

Aims of the review

The aims of the review were:

1) To identify any excess mortality or clusters of deaths among patients who were on Daedalus and Dryad wards 1988-2000 and to identify initial evidence to explain any excess or clusters.

2) To determine whether the numbers of deaths among Dr Barton's general practice patients was higher than would have been expected.

Palliative and terminal care

Some understanding of current practice and policies on the care of dying patients is required in order to enable judgements to be made about the appropriateness of care given to patients who died in Gosport War Memorial Hospital. This section outlines relevant features of this aspect of care.

The World Health Organisation (WHO) defines palliative care as 'the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families' (O'Neill and Fallon, 1997). Palliative care for people with advanced cancer is now widely available. However, people with other chronic progressive

conditions may also need palliative care when other treatment ceases to be of benefit. Such conditions include advanced respiratory, cardiac or neurological disease (O'Brien et al, 1998). Some of the patients who died on Daedalus and Dryad wards had dementia, and in recent years, it has been increasingly recognised that palliative care also has a role to play in advanced (or 'end stage') dementia. Since a basic awareness of the care of the people with advanced dementia is required in order to interpret the findings of this review, an outline of selected key issues follow.

In advanced dementia, death occurs as a consequence of the many secondary impairments that arise, including progressive immobility, reduced ability for self-care, poor nutrition and reduced intake of fluids, infections related to immobility, skin breakdown, and general debilitation (Shuster, 2000). Although patients dying from dementia have symptoms and health care needs comparable with cancer (McCarthy et al, 1997), patients on long-stay wards who are dying at the end stage of dementia do not always received appropriate palliative care.

In a study undertaken in a long-stay psychogeriatric unit in England, patients with end stage dementia were found to have many symptoms, including pain, dyspnoea and pyrexia for which no palliative treatment was given. Instead, there was widespread use of parenteral antibiotics and infrequent use of analgesia in the last few days of life (Lloyd-Williams 1996). In a follow-up to this study, guidelines on palliative care in end stage dementia were developed, and an increase in the use of analgesics including opiates occurred (Lloyd-Williams and Payne, 2002). The data collected after the implementation of the guidelines related to the deaths of 27 patients, of whom 13 (48%) were prescribed 4-hourly morphine for the palliation of pain or shortness of breath (caused by pneumonia). Two patients who were unable

to take oral medication were commenced on diamorphine administered by syringe drivers. It should be noted that pneumonia can cause significant symptoms in people with dementia, including shortness of breath and discomfort (Steen et al, 2002). Deficiencies in palliative care of elderly patients with or without dementia are also found in other countries (Fox et al, 1999; Evers et al, 2002; Morrison and Siu, 2000).

Information about a palliative care service for elderly people in the same district as Gosport is pertinent to the review. In 1989, a 12-bedded palliative care ward was opened within the Geriatric Department at Queen Alexandra Hospital, Portsmouth (Severs and Wilkins, 1991). The aim was to improve the care of elderly people at the end of life. In the first year, 128 patients were admitted to the ward, of whom 101 (78.9%) had cancer, 17 had strokes and two had dementia. The service was therefore primarily caring for elderly people with terminal cancer.

Guidelines

Communication between professionals (nurses and doctors), and between professionals and relatives or dying elderly patients is sometimes poor (Costello, 2001), and decisions on whether resuscitation would be appropriate ('do not resuscitate' or DNR orders) may not be fully discussed (Costello, 2002). Wider use of clinical guidelines might assist health professionals overcome these problems and provide palliative care to more of those patients who need it. A growing number of publications offer guidance about palliative care for patients with cancer, but the two clinical guidelines discussed here illustrate current professional opinion about the care of people in the terminal phase of dementia. The first guideline was developed in a long-stay hospital in England (Lloyd-Williams and Payne, 2002), and was

concerned with the palliative care of patients with end stage dementia. It is summarised in Box 1.4.

Box 1.4. Guidelines for the management of patients with end stage dementia (from: Lloyd-Williams and Payne, 2002)

Consider treatable causes of pain (e.g. pressure sores, full bladder); use oral medication when possible, and administer on a regular basis; use co-proxamol initially; if still in pain, consider a non-steroidal anti-inflammatory drug.

When opiates are used, start with a low dose and increase as needed to control pain; always prescribe diamorphine 2.5-10mg for injection on an as required basis so that analgesia can still be given if the oral route is not available.

When converting from oral subcutaneous opiates, remember to divide the total oral dose by three e.g. 60mg oral morphine in 24 hours = 20mg diamorphine in syringe driver.

In the event of agitation, think of full bladder; midazolam 2.5mg-10mg subcutaneously or oral haloperidol or thioridazine may be used.

The most common cause of dyspnoea is bronchopneumonia. There is no evidence that using antibiotics in end stage dementia is helpful or improves patients' comfort or prolongs the quality of life. Oral morphine 5mg 4-hourly can reduce the sensation of breathlessness and improve patient's comfort.

The second guideline mentioned here was developed to help physicians decide whether to forgo curative treatment of pneumonia in patients with dementia resident

in nursing homes, and has been developed by a research group in the Netherlands (Steen et al, 2000). The guidelines were based on a literature review, discussion papers prepared by Dutch medical associations, and consensus procedures with experienced nursing-home physicians and international experts in the fields of nursing-home medicine, ethics and law. The guidelines were subsequently authorized by the Dutch professional organisation of nursing home physicians. The guidelines were presented in the form of a checklist for use by physicians in nursing homes (see Box 1.5.).

Box 1.5. Checklist on decision for starting or not starting a curative treatment of pneumonia in a patient with dementia (Steen et al, 2000).

The key factors to consider are:

1. the expected effect of a curative treatment from the medical perspective
2. the patient's wish: a living will, or the reconstruction of the wish
3. the patient's best interest when the wish of the patient is not clear, or remains unknown.

The checklist considerations:

1. Is an intentionally curative treatment indicated for this patient?
2. How physically and/or psychiatrically burdensome would the total curative treatment – antibiotics and (re)hydration – be for the patient?
3. Is the patient sufficiently mentally competent to indicate their wish, and if so, what treatment does the patient want?
4. What is the purport of the written will?
5. What is the purport of the reconstruction of the patient's will according to the representative(s)?
6. What is the purport of the reconstructed patient's wishes according to the other involved professional carers?
7. Which treatment seems to be in the patient's best interests (not certain, intentionally curative treatment, or palliative treatment)?

An important step in palliative care is the point at which terminal care begins. The factors that lead to the decision to begin terminal care will depend on the stage of the patient's disease. An example of criteria that may be used for initiating terminal care is shown in Box 1.6 (Edmonds and Rogers, 2003).

Box 1.6. Criteria for starting an integrated care pathway for patients dying in hospital (from Edmonds and Rogers, 2003)

Patients who have a known diagnosis and have deteriorated despite appropriate medical intervention. The multiprofessional team have agreed the patient is dying and at least two of the following apply:

The patient:

1. is bedbound
2. is only able to take sips of fluids
3. has impaired concentration
4. is semi-comatose
5. is no longer able to take tablets

General Medical Council Guidance

In 2002, the general Medical Council (GMC) (GMC, 2002) issued guidance on withholding life-prolonging treatment. Much of this guidance is not directly relevant to an assessment of the care of patients at Gosport, but the guidance does state guiding principles dealing with respect for human life and patients' best interests. These make clear what is expected of doctors in the UK, and are relevant to judgements that may be made about the care of people under the care of the Department of Medicine for Elderly People at Gosport Hospital. The relevant section of the guidance is quoted in full in Box 1.7.

Box 1.7 Respect for Human Life and Best Interests (GMC, 2002)

Doctors have an ethical obligation to show respect for human life; protect the health of their patients; and to make their patients' best interests their first concern. This means offering those treatments where the possible benefits outweigh any burdens or risks associated with the treatment, and avoiding those treatments where there is no benefit to the patient.

Benefits and burdens for the patient are not always limited to purely medical consideration, and doctors should be careful, particularly when dealing with patients who cannot make decisions for themselves, to take account of all the other factors relevant to the circumstances of the particular patient. It may be very difficult to arrive at a view about the preferences of patients, who cannot decide for themselves, and doctors must not simply substitute their own values or those of the people consulted.

Prolonging life will usually be in the best interests of a patient, provided that the treatment is not considered to be excessively burdensome or disproportionate in relation to the expected benefits. Not continuing or not starting a potentially life-prolonging treatment is in the best interests of a patient when it would provide no net benefit to the patient. In cases of acute critical illness where the outcome of treatment is unclear, as for some patients who require intensive care, survival from the acute crisis would be regarded as being in the patient's best interests.

End of natural life

Life has a natural end, and doctors and others caring for a patient need to recognise that the point may come in the progression of a patient's condition where death is drawing near. In these circumstances doctors should not strive to prolong the dying

process with no regard to the patient's wishes, where known, or an up to date assessment of the benefits and burdens of treatment or non-treatment.

Notes on selected drugs

1. *Morphine and diamorphine*

Important sections of the review are concerned with the use of selected drugs towards the end of life. Brief notes about relevant drugs are included here for those who may not be familiar with them. The transition from the weaker to the stronger analgesics is usually described in terms of a three step ladder (Twycross et al, 1998), beginning with non-opioid analgesics such as paracetamol (step one), followed by the addition of a weak opioid such as codeine or dextromoramide (step two), the final step being the addition of a strong opioid.

Morphine and diamorphine are both strong opiate analgesics. Although there is a risk of dependence if the drugs are administered repeatedly, the British National Formulary (2001) makes clear that this should not be taken as a reason for not using regular opiates in terminal care. Morphine is the treatment of choice for oral treatment of severe pain in palliative care, and a dose of 5-10mg given every 4 hours is enough to replace a non-opioid analgesic such as paracetamol or a non-opioid and weak opioid used in combination (for example, paracetamol with dihydrocodeine). However, the dose should be increased stepwise according to response. Oramorph is a pharmaceutical company's name for a particular preparation of oral morphine. Modified release preparations suitable for twice daily administration are available as tablets (for example MST Continus), capsules or in suspension.

If the patient becomes unable to swallow, intramuscular morphine may be given, the equivalent dose being half the dose of the oral solution. However, diamorphine is preferred for injection because it is more soluable and can therefore be given in smaller volumes. The equivalent intramuscular or subcutaneous dose of diamorphine is one third the oral dose of morphine (Twycross et al, 1998). Thus, if a patient has been receiving 10mg of morphine oral solution every 4 hours (a total of 50 mg in each 24 hours), the equivalent dose of diamorphine administered subcutaneously by syringe driver would be approximately 17 mg in 24 hours.

Agitation, confusion and myoclonic jerks occur as a consequence of opiate toxicity. These features may be interpreted as un-controlled pain, leading to the administration of more opiate medication. The consequences are increased sedation, dehydration and further toxicity (O'Neill and Fallon, 1997).

2. *Fentanyl*

Fentanyl (Durogesic) is a strong opioid analgesic that can be absorbed through the skin, and is therefore administered by self-adhesive patches applied to the skin. The patch releases a defined dose per hour over a period of 72 hours, after which the patch should be replaced.

3. *Haloperidol*

Haloperidol is given in syringe drivers to control nausea and vomiting, in doses of 2.5 to 10mg in 24 hours. It is an antipsychotic, but has little sedative effect.

4. *Hyoscine hydrobromide*

Hyoscine hydrobromide is used to control respiratory secretions and is given by syringe driver in doses of 0.6 to 2.4 mg per 24 hours. Drowsiness is a side-effect

5. *Midazolam*

Midazolam (Hypnovel) is a benzodiazepine sedative and is suitable for the very restless patient, in doses of 20 to 100 mg in 24 hours. Drowsiness is a side-effect, and haloperidol is an alternative if symptoms are not controlled by doses of 30mg or less per 24 hours (Twycross et al, 1998)

The Wessex Guidelines

Local guidelines on palliative care were available to health professionals in Gosport. They were published by the Wessex Specialist Palliative Care Unit, and were referred to as the "Wessex Guidelines". The edition of the guidelines current in 1998 recommended assessment of pain, including the site, severity, duration, timing, and aggravating and relieving factors. The use of a body diagram and the patient's own words were recommended as part of the assessment. Depending on the findings of the assessment, analgesics if appropriate were advised, in accordance with the three steps in the WHO analgesic ladder (step one non-opioids, step 2 weak opioids, step 3 strong opioids). The guidelines included advice about the choice of opiate analgesics, and selection of dose, the recommendations being in accordance with the notes and drugs discussed above. The guidelines noted that the use of nebulised opioids was not supports by scientific evidence and might induce bronchospasm. The guidelines address all aspects of clinical management in palliative care, in addition to use of medication.

An Overview of The Report

The review is presented in the following six Chapters. Chapter Two reports an investigation of a random sample of clinical records of patients who died between 1988 and 2000. The review of records was undertaken following review of five records of patients whose deaths were being investigated by the police, and sought to describe clinical practice in the Department of Medicine for Elderly People at Gosport hospital.

In Chapter Three, an analysis of the numbers of deaths in Gosport hospital 1988-2000 is presented, the data being based on counterfoils of medical certificates of the cause of death completed by doctors at the hospital. The data are used to describe the certified causes of death, to identify clusters of deaths, and the features of patients whose deaths had been certified by Dr Barton. The Chapter also outlines the difficulties encountered in use of Hospital Episode Statistics to explore patterns of deaths in Gosport hospital.

Chapter Four presents the findings of a review of information obtained from admissions books from Dryad ward. The admissions books contain information about the duration of admission, whether patients had died or were discharged from the ward, the place patients were admitted from, and some indication of the reason for admission.

An investigation of information contained in retained controlled drugs registers is reported in Chapter Five. Data in the registers indicate which patients received opiate medication, how much medication they received, and the wards on which patients were staying. The information was related to information from the

counterfoils of medical certificates of the cause of death to investigate the proportions of people who died who had received an opiate.

Chapter Six presents information obtained from medical certificates of the cause of death completed by Dr Barton and a comparison sample of general practitioners. This analysis was undertaken to determine whether the numbers of deaths among patients in general practice was as expected. Finally, Chapter Seven presents the conclusions and a small number of recommendations.

Ethics approval

Approval for access to data from Hospital Episodes Statistics and National Statistics was obtained from the ethics committees of these organisations. The methods of the audit were discussed with the Chair of the Isle of Wight, Portsmouth and SE Hants Local Research Ethics Committee, and it was confirmed that it was not a research study that required approval. The audit has been undertaken in accordance with the guidance of the GMC on confidentiality. In the Chapters that follow, care has been taken to exclude any material that might lead to the identification of individual patients.

Much of this review is focused on the work of Dr Barton. This should not be taken as meaning that Dr Barton was the origin of approach followed at Gosport hospital, or that her clinical practice was the key problem that has given rise to the concerns expressed by relatives. Since Dr Barton issued most of the medical certificates of cause of death for patients of the Department of Medicine for Elderly People, made most of the entries in the clinical records, and was responsible for most of the prescribing, she has served as a means of identifying patients and care that should be included in the review. However, it should be recalled that she was a member of a

clinical team, and the review has not investigated the process of decision making in the clinical team. The audit relied on documentary evidence about care of patients at Gosport, and did not involve consideration of statements from individuals. Therefore, conclusions about the actions of individuals should not be reached since they have not had the opportunity of presenting their own side of the story.

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Chapter Two. Review of records

A review of records of cases reported to Hampshire Constabulary

In 1998, the initial police investigation into care of patients at Gosport War Memorial Hospital was prompted by the death of one patient that was reported to the police by the family of the deceased as a potential case of unlawful killing. In the months that followed, other families who had become aware of concerns about care at the hospital also contacted the police. From the cases notified to them, the police had, by December 2002, identified five cases that shared certain features that indicated the need for detailed investigation. The police permitted me to review the clinical records of these cases.

The aim of the review of these records was to identify those features recorded in the records that might give rise to concern about the care patients had received and the cause of death. The police had invited a small number of clinical experts to review the records, but I did not consult the reports of these experts in order to ensure that an independent opinion was reached. The records available included all those made by medical and nursing staff at Gosport War Memorial Hospital, drug charts, X rays and investigation reports, records made by staff in acute hospitals in the case of those patients who had been transferred to Gosport from another hospital, and correspondence from patients' general practitioners. The features identified from the five sets of records were:

1. *All were frail, with major clinical problems.* All five had been admitted to Gosport War Memorial Hospital from other services, for example from acute hospital following surgery for a fractured hip, or from a day hospital. All were

dependent on nursing care and had more than one health condition, including for example Alzheimer's disease, Parkinson's disease, or cancer. Their continuing problems included pressure sores, mobility, confusion and incontinence.

2. *In some cases, active treatment had been planned.* Some, although not all of the five patients had been admitted to Gosport to enable active treatment to be arranged, for example rehabilitation after a fractured hip, or aggressive treatment to heal a sacral ulcer. It should be noted, however, that in one case admission was for palliative care, and in another the prognosis had been noted as poor prior to transfer from an acute hospital.
3. *Oramorph was written on the drug chart on admission.* In four of the five cases, Oramorph was prescribed although not necessarily administered on the day of admission.
4. *Diamorphine was administered by syringe driver in all cases.* Diamorphine was commenced when a patient had pain not otherwise controlled, was noted to be agitated, or had deteriorated in some way. Diamorphine was usually administered with hyoscine and midazolam.
5. *Doses of opiates were unexceptional.* Patients were not given extremely high doses of diamorphine or Oramorph, although it should be noted that they were all frail and elderly, and diamorphine was administered along with midazolam.
6. *The records did not contain full explanations for the treatment decisions.* The medical records were generally rather brief, although the amount of detail varied between doctors. Consultants tended to make more detailed notes. The reason for selecting morphine rather than a non-opiate analgesic was not recorded, even though in some cases other analgesics had not been used. Likewise, the decision to initiate subcutaneous diamorphine by syringe

driver or the reasons for not investigating the potential causes of new symptoms such as pain or agitation were often not fully described.

7. *Remarks in the records suggested a conservative rather than active attitude towards clinical management.* Two of the five records included the instruction by a doctor to nursing staff: 'Please make comfortable'; three records included: 'I am happy for nursing staff to confirm death', written by Dr Barton in all cases on the day of admission.

Review of a random sample of records

Having identified features of cases that the police had been investigating, a review of a random sample of records of patients who had died in Gosport War Memorial Hospital was undertaken. The aims of the review were to (a) determine whether other cases shared these features, and (b) describe the pattern of care of patients who died in the hospital. The review concentrated on patients who had been under the care of Dr Barton, since the medical certificates of cause of death (MCCD) of most patients who had died on Daedalus and Dryad wards had been issued by Dr Barton. Most MCCDs issued by Dr Barton would have been for patients who have been under the care of the Department of Medicine for Elderly People.

Method

Patients whose deaths had been certified by Dr Barton between 1987 and 2002 were identified by National Statistics. From 1993 onwards, information about deaths has been stored on a computer system by National Statistics, and those certified by Dr Barton were readily identified. However, prior to 1993 information was stored on paper only, and a hand search of files containing information about deaths notified in districts local to Gosport was required. The information held on computer or paper

systems consists of details recorded by the certifying doctor on the MCCD, and associated information provided to the registrar of births, marriages and deaths by the informant, who is usually a relative of the deceased. In this report, the summaries of the information from these two sources combined are referred to as death notifications. In addition to the name of the deceased, date of death, and certified cause of death, the information available includes the name of the doctor who issued the MCCD, and the place of death.

The sample of records selected for review was taken from the notifications provided by National Statistics. The review sampled cases from 1988 until 2000, from the beginning of Dr Barton's work at the hospital until she left her post of clinical assistant. A 10% sample of the 833 deaths certified by Dr Barton during this period was selected using the random sampling procedure in the Statistical Package for the Social Sciences (SPSS), the principal statistics software employed in this review.

The hospital records of all deceased patients had been retained by Portsmouth Healthcare NHS Trust for all years during which Dr Barton worked at Gosport, although records of patients who died in 1995 or before had been stored on microfiche. The record department of Gosport War Memorial Hospital was asked to provide all the sampled records, and once these had been retrieved, the review was undertaken. The information extracted from each record is shown in Table 2.1. The notes recorded by both doctors and nurses were reviewed, and drug charts were also inspected. In addition, in each case my own observations on the patient's care were recorded, and the cause of death as certified by Dr Barton was noted. Causes of death were grouped into six categories, according to the first cause of death noted on the MCCD. Thus, the category 'cancer' included all deaths in which a type of cancer was given as the first cause of death. Heart conditions included myocardial

infarction, heart failure, ischaemic heart disease, and other heart disorders. Stroke included both cerebral thrombosis and cerebral haemorrhage. Some certificates gave bronchopneumonia as the sole cause of death, and these were placed in a category distinct from deaths certified as due to bronchopneumonia associated with other conditions that included cancer, dementia, or other disorders. The 'other' category included dementia, old age, renal disease, progressive neurological conditions and other medical conditions not included in the five other categories.

Table 2.1. Information extracted from the clinical records

	Information collected from records
1	Age and gender
2	Date of admission
3	Past medical history
4	History of the final illness
5	Administration of opiate medication

Results

The sample consisted of 85 patients. The records of four were held by the police and therefore were excluded from this review. All the remaining 81 records were reviewed. The numbers of records in each year are shown in Table 2.2. The mean age of patients in the sample was 84.5 years (95% confidence interval 82.8-86.1), and in the group not sampled 82.7 years (95% confidence interval 82.2-83.3). The proportion of females was slightly higher in the sample than in the group not in the sample (Table 2.3), although this did not reach statistical significance (Chi Sq 3.26, df 1, p 0.07). There was no difference between the groups of patients included in and excluded from the sample with respect to the numbers of patients certified as dying from different categories of illness (Chi Sq 3.02, df 5, p 0.70) (Table 2.4).

Table 2.2. Numbers of deaths in Gosport War Memorial Hospital certified by Dr Barton in total, and numbers in sample, 1988-2000.

Year	Number of patients in sample	Number of deaths certified by Dr Barton
1988	2	19
1989	4	30
1990	3	38
1991	6	31
1992	2	32
1993	10	94
1994	8	104
1995	7	80
1996	8	84
1997	11	86
1998	7	107
1999	12	92
2000	1	34
Total	81	833

Table 2.3. Numbers (%) of males and females in the sample compared to those not in the sample the (the Table does not include the four cases excluded from the sample).

Gender	Not in sample	In sample	Total
male	337 (45.1)	28 (34.6)	365 (44.0)
female	411 (54.9)	53 (65.4)	464 (56.0)
total	748	81	829

Table 2.4. Numbers (%) of deaths due to different categories of disease, in those patients included in and excluded from the sample.

Category of disease	Not in sample	In sample	Total
Cancer	44 (5.9)	5 (6.2)	49 (5.9)
Heart	85 (11.4)	7 (8.6)	92 (11.1)
Stroke	122 (16.3)	13 (16.0)	135 (16.3)
bronchopneumonia + other conditions	331 (44.3)	33 (40.7)	364 (43.9)
bronchopneumonia only	139 (18.6)	21 (25.9)	160 (19.3)
Other	27 (3.6)	2 (2.5)	29 (3.5)
total	748	81	829

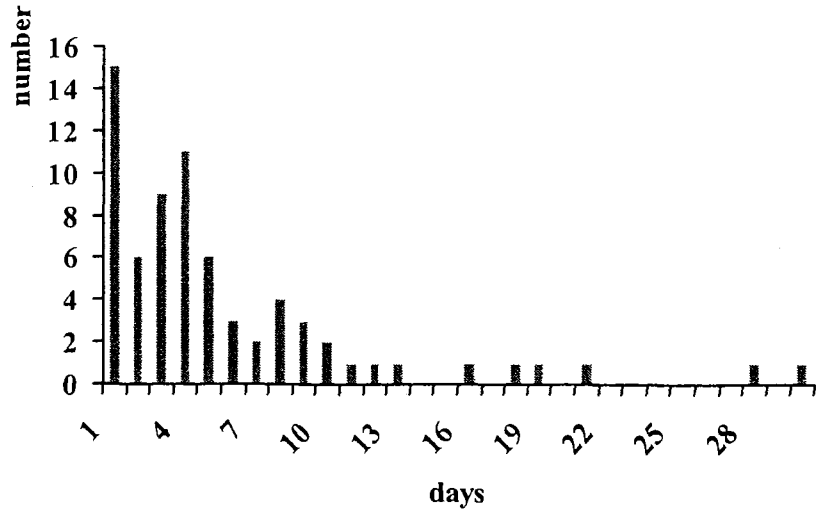
The patients in the sample were almost all elderly; all except two were aged 70 or over (one was aged 69 and one 60). Twenty-one (25.9%) were aged 90 or above (one was aged 100). Typically, patients had been transferred to Gosport following admission to an acute hospital for a major illness, the transfer to Gosport being arranged because the patient would have required more support than could have been provided in a nursing home. In some cases, the aim of transfer to Gosport was rehabilitation, for example, following a stroke or fractured hip. In others, the aim was long term care, as in patients with lasting disabilities following major strokes, or with terminal cancer. Many patients also had other comorbid conditions contributing to the development of dependence on nursing care, including advanced dementia and cardiovascular disease.

Table 2.5. Numbers (%) of patients who received opiate medication before death

	N	%
None	5	6.2
Diamorphine only	21	25.9
Oramorph and diamorphine	38	46.9
Other oral opiates and diamorphine	13	16.0
Other opiates, no diamorphine	4	4.9
Total	81	100.0

Most patients had received an opiate before death (Table 2.5). The most common pattern was initial use of Oramorph, followed by diamorphine subcutaneously. When used in a syringe driver in this way, diamorphine was invariably accompanied by other drugs. In 1988, diamorphine was used in combination with atropine, but in subsequent years it was combined with hyoscine and midazolam. In one case, the duration of opiate medication could not be determined from the records. The other 76 who received opiates were administered the drugs for a median of four days (range 1 – 120 days, inter-quartile range 7 days) (see Figure 2.1).

Figure 2.1. Duration of administration of opiate medication (chart excludes 2 patients at 42 days, 3 at 90 days and 1 at 120 days).



The pattern of use of opiates in these patients generally involved the administration of an oral opiate for pain or distress from whatever cause, followed by the use of subcutaneous diamorphine when the patient became unable to swallow oral medication. This process was usually triggered by a deterioration in health. An example taken from the medical records is as follows:

'further deterioration. Uncomfortable coughing, to have a tiny dose of oramorph regularly JAB' (JAB are Dr Barton's initials) (Case 1210).

Oramorph would also be commenced by other doctors, for example:

Oedema worse, relative feels patient has had enough. Oramorph started. (Signature not clear) (Case 1209).

If the patient deteriorated further, subcutaneous diamorphine would be used, for example:

'Further deterioration in general condition. In pain, confused and frightened. sc analgesia commenced. JAB' (Case 1139).

or:

'patient has deteriorated over weekend, pain relief is a problem. I suggest starts sc analgesia and please make comfortable. I am happy for nursing staff to confirm death. JAB' (Case 708).

The initial dose of diamorphine varied from 5 mg to 80 mg in 24 hours, doses below 20 mg being administered intramuscularly, and doses of 20 mg or more being administered subcutaneously by syringe driver. Of the 60 patients in whom the starting dose of diamorphine could be established, the most common dose was 40mg (50.8%), followed by 20 mg (31.7%) (Table 2.6). Of the 19 who received 20 mg diamorphine in 24 hrs, the dose of oral morphine being administered before

diamorphine was commenced could be identified in seven. The mean total daily dose of oral morphine in these cases was 27.1 mg. Of the 31 who received a starting dose of diamorphine of 40 mg in 24 hours, the daily dose of oral morphine before changing to subcutaneous diamorphine could also be established in seven cases, and the mean morphine dose in these was 44.3 mg. It is generally recommended that to obtain an equivalent level of pain relief, the dose of diamorphine on transfer from oral morphine should be one third of the total daily oral dose (see Chapter One). If this guidance is followed, a starting dose of subcutaneous diamorphine of 20 mg would equate to a daily dose of oral morphine of 60 mg, and a 40 mg dose of diamorphine would equate to a 120 mg dose of oral morphine in 24 hours.

Table 2. 6. Numbers (%) of patients receiving different starting doses of diamorphine

Diamorphine (mg)	N	%
5	1	1.7
10	2	3.3
15	1	1.7
20	19	31.7
30	2	3.3
40	31	50.8
60	1	1.7
80	3	5.0
Total	60	

The use of opiates was not confined to patients with cancer. Only two (15.4%) patients who were certified as having died from strokes did not receive an opiate, and only three (9.1%) of those who were certified as dying from bronchopneumonia associated with other conditions did not receive an opiate (Table 2.7).

Table 2.7. The certified causes of deaths of patients and the numbers (%) who received an opiate.

	Opiates					Total
	none	*diamorphine only*	*oramorph then diamorphine*	*other opiates then diamorphine*	*other opiates*	
cancer	0	1 (20.0)	3 (60.0)	0	1 (20.0)	5
heart	0	2 (28.6)	2 (28.6)	2 (28.6)	1 14.3)	7
stroke	2 (15.4)	3 (23.1)	8 (61.5)	0	0	13
bronchopneumonia with other conditions	3 (9.1)	10 (30.3)	15 (45.5)	5 (15.2)	0	33
bronchopneumonia alone	0	5 (23.8)	9 (42.9)	5 (23.8)	2 (9.5)	21
other conditions	0	0	1 (50.0)	1 (50.0)		2
Total	5 (6.2)	21 (25.9)	38 (46.9)	13 (16.0)	4 (4.9)	81

Typically, a deterioration in a patient's condition would not be investigated in depth. In many cases this would have been appropriate, since the advanced state of illness and impossibility of further curative or rehabilitative treatment had been well established. However, in some cases, the resort to opiate medication might have been, but was not, preceded by some investigation, or trial of analgesics other than opiates. The degree of assessment of pain recommended in the 'Wessex guidelines' was not usually evident in the records, and body maps to highlight areas of pain were not used. For example:

– *'frightened agitated appears in pain suggest transdermal analgesia despite no obvious clinical justification!! Dr Lord to countersign. I am happy for nursing staff to confirm death. JAB'* (Case 785).

In 18 (22.2%) cases the drug chart could not be reviewed because a copy had not been stored on microfiche. Nonetheless, in these cases it was possible to describe the use of opiate medication from entries in the medical and nursing records. Drug charts were almost always completed by Dr Barton. It was notable that in many cases, prescriptions for opiate medication had been entered by Dr Barton on drug charts on the day of the patient's admission, although the medication was not administered until some days or even weeks later. For example, in the case of a patient who had abdominal obstruction and had been admitted to Gosport from an acute hospital, diamorphine was entered onto the drug chart on the day of admission, but not administered until 16 days later (Case 597). Prescriptions for diamorphine typically indicated a range of dose, to enable adjustment without a new prescription being written. In the example just mentioned, the indicated dose was 20-80 milligrams subcutaneously in 24 hours, to be administered with hyoscine and midazolam. It was not unusual for entries in the records by Dr Barton on the day of admission to include the statement '*I am happy for nursing staff to confirm death JAB*' (e.g. Case 530).

The proportion of patients who received an opiate before death did not vary significantly from year to year (Table 2.8). Of the nine deaths that occurred between 1988 and 1990, seven had received an opiate, and it therefore appears that the almost routine use of opiates before death had been established at Gosport hospital long before the initial complaint in 1998.

Table 2.8. Numbers (%) of patients who received an opiate before death, 1988-2000 (Chi Sq 50.0, p not significant).

year	Opiates					Total
	none	*diamorphine*	*oramorph plus diamorphine*	*other plus diamorphine*	*other only*	
1988	1 (50.0)			1 (50.0)		2
1989	1 (25.0)	3 (75.0)				4
1990		2 (66.7)		1 (33.3)		3
1991	1 (20.0)	1 (20.0)	1 (20.0)	2 (40.0)		5
1992			1 (50.0)	1 (50.0)		2
1993		4 (36.4)	3 (27.3)	3 (27.3)	1 (9.1)	11
1994	1 (12.5)	3 (37.5)	4 (50.0)			8
1995		2 (28.6)	5 (71.4)			7
1996		1 (12.5)	6 (75.0)		1 (12.5)	8
1997	1 (9.1)	2 (18.2)	6 (54.5)	2 (18.2)		11
1998		1 (14.3)	3 (42.9)	2 (28.6)	1 (14.3)	7
1999		2 (16.7)	8 (66.7)	1 (8.3)	1 (8.3)	12
2000			1 (100.0)			1
	5 (6.2)	21 (25.9)	38 (46.9)	13 (16.0)	4 (4.9)	81

The medical records were often limited. In 32 (39.5%) of the cases reviewed, the records were judged to be too brief to enable an adequate assessment of care to be made. In particular, they did not always contain information about the decision to initiate opiate medication.

In the review, it was possible to relate information contained in the records to the information reported on death certificates. In 42 (51.9%) cases, the information on certificates was judged to be an incomplete statement of factors contributing to

death. In 16 of these, a recent fracture that had contributed to the patient's condition had not been reported on the death certificate. These included patients who had suffered a fractured hip and undergone operative fixation or partial hip replacement in an acute hospital prior to transfer to Gosport. Indeed, a fracture had not been mentioned on any of the death certificates in the sample. Typically, death in these cases was reported as being caused by bronchopneumonia.

Forty-eight records contained sufficient details to enable a judgement to be made about the appropriateness of care. In 32 (66.7%) of these, care was judged to have been appropriate. There were some concerns about the decision to start opiate medication in the remaining 16 (33.3%). The indications for starting the drugs were either not clearly stated, or if pain was mentioned it had not been investigated, and neither remedial treatment or alternative analgesia had been attempted. For example, the following was written in one set of records in Dr Barton's handwriting: *'marked deterioration over last 24 hrs. Persistent cough relieved by nebulised diamorphine in N/saline. .... Sc analgesia is now appropriate + neb if required'* (Case 587). No investigation of the cough was described nor treatment other than nebulised diamorphine.

Discussion

A number of qualifications about the review of records should be acknowledged. The information was obtained from the records only, and because of the pressure of routine care in a hospital ward, clinicians may often fail to record extensive details about patient care. In some cases, the drug charts that recorded prescribing and administration of opiate medication were not available because they had not been copied onto microfiche. More complete records, or information obtained through interviews of clinical staff or relatives, might have explained some of the findings

that, on the evidence of the records alone, gave rise to some concern. The sample included only patients whose deaths had been certified by Dr Barton. However, the records contained entries from other doctors, and demonstrated that they had made some treatment decisions.

The record review was undertaken to identify broad patterns of care, and therefore included a relatively large number of cases, albeit a sample from over 800 cases. An intensive, prolonged and in depth review of a small number of cases might have reached, in those cases, different conclusions. Nevertheless, despite these reservations, the review does raise questions about the care provided to patients at Gosport War Memorial Hospital.

Features of care

The first aim of the review was to determine whether features associated with the care of patients whose deaths were being investigated by the police could also be found in the sample.

1. All patients were severely ill, having major disabling, or progressive conditions, or illnesses that were unlikely to substantially improve. They were heavily dependent on nursing care, and many had been intensively investigated and treated in acute hospitals before transfer to Gosport.
2. The precise reasons for admission were not always clear from the records, but some patients had certainly been admitted for rehabilitation. The majority of patients, however, had major clinical problems.
3. 93.8% of patients received an opiate, and almost half received Oramorph (Table 2.5). Opiate medication was frequently prescribed on the day of admission, although there was no immediate indication for their use, and they

were sometimes not administered until after several days or weeks. There was little evidence of use of weak or moderate analgesics before resort to oral morphine, opiate medication being used when patients suffered a deterioration in their condition. Further investigation or active treatment were often not undertaken, and alternative analgesics were generally not used first. If pain was a feature of a patient's deterioration, a detailed assessment of the reasons for pain was not usually recorded.

4. Diamorphine was administered to 72 (88.9%) patients, almost always by syringe driver and accompanied with other drugs with sedative properties, most commonly midazolam and hyoscine. Diamorphine was used in all categories of condition (Table 2.7). In those patients in whom the dose of oral morphine could be established, the starting dose of diamorphine tended to be higher than would have been expected. The two potential explanations are that oral opiates were not being administered at sufficient doses to control pain, or that the doses of diamorphine were greater than required.
5. In most cases, opiates were not used for prolonged periods, 47 (61.8%) patients dying within five days of starting treatment.
6. The records were generally brief. On occasions, details were either not recorded, or no entries were made when the patient had been assessed by a doctor, although the consultation was mentioned in the nursing records. The reasons for starting opiate medication were often not adequately recorded, and in 39.5% of cases it was not possible to assess the appropriateness of care.
7. The conservative attitude to treatment identified in the records of the cases being investigated by the police was also evident in the records of the sample. The quotations included above serve to illustrate this finding. The

initial medical assessment of a patient on admission was often concluded with the phrase 'Please make comfortable'.

8. In the case of patients whose deaths had been preceded by a bone fracture (most commonly the hip), Dr Barton did not note the fracture on the medical certificate of cause of death. The Office of National Statistics (ONS) encourages the practice of voluntary referral to the coroner by the certifying doctor of deaths due to accidents (whenever the accident occurred) (Devis and Rooney, 1999). It is conceivable that the local coroner would have undertaken at least some investigation into a number of the deaths that had followed fractures.

The pattern of care

The review included records of patients who died from 1988 to 2000. The findings reveal a distinct pattern dating from 1988. Indeed, the almost routine use of opiates before death appears to date from at least as early 1988, but it is conceivable that this practice was in use before this, and before Dr Barton was appointed as clinical assistant.

The patients admitted to Gosport War Memorial Hospital under the care of the Department of Medicine for Elderly People were old and frail. They had major illnesses and were heavily dependent on nursing care. In managing these patients, the culture at Gosport throughout the period appeared, from the records, to have been conservative with regard to treatment and modest with regard to expectations of improving patient health. It may be summed up in Dr Barton's own words, frequently written in the records: 'Please make comfortable'. This approach may have been entirely correct for many of the severely ill and dependent patients

admitted to Gosport. However, it is possible that in some patients, a more active clinical approach would have extended life.

Opiates were used extensively, and often without recourse to other analgesics, detailed assessment of the cause of pain, agitation or deterioration, or active treatment. The doses of diamorphine appear to have been higher than prior doses of oral morphine would have suggested were required, and most patients died within a few days of starting opiates. These observations might be interpreted as indicating that management of patients with terminal illnesses, in placing so much emphasis on the comfort of the patient, were in advance of those followed elsewhere in the health service. However, they might also be interpreted as indicative of a conservative approach to treatment, and even a premature resort to opiates that in some cases may have shortened life.

The lack of detail recorded in the notes about medical decisions, and contrast between the detailed notes written by the consultants and the short entries of other doctors – sometimes written within a few hours of each other – suggests that the level of supervision and teamwork was poor. The failure of the records to provide a coherent description of a patient's illness and care, the often disjointed nature of entries by different doctors, and the lack of detail about some decisions may have been a consequence of inadequate discussion between members of the clinical team on patient management.

The completion of medical certificates of cause of death was inadequate. In particular, the pattern of not reporting recent fractures was not appropriate.

References

Devis T, Rooney C (1999). Death certification and the epidemiologist. *Health Statistics Quarterly*, Spring, 21-33.

Chapter Three: Deaths at Gosport War Memorial Hospital, 1987-2000: A review of Medical Certificates of Cause of Death (MCCDs) counterfoils

Introduction

Medical certificates of cause of death are supplied in books, each book containing 50 certificates. Each certificate is attached to a counterfoil from which it is detached when it is issued. At Gosport, only one book of MCCDs was in use at any one time, the book being held in an office close to the mortuary. It was hospital policy that MCCDs should be issued from the centrally held book, and the books of counterfoils have been retained for a number of years. Consequently, the counterfoils are likely to represent a reasonably complete record of deaths for which an MCCD was issued, although deaths that were referred to the coroner would have been excluded. This chapter describes the findings from review of these counterfoils.

The counterfoils record selected information that is also entered on the MCCD itself, including the deceased's name, date of death, the place of death, and the cause of death. From early 1988, the counterfoils of the books of certificates in use at Gosport also required the certifying doctor to state the deceased's age.

Method

Information from all the available counterfoils was entered into a database. The specific data items are shown in Table 3.1.

Table 3.1. Information obtained from the MCCD counterfoils.

1	Name
2	Gender
3	Age
4	Date of death
5	Certified cause(s) of death
6	Doctor completing the certificate
7	Place of death

The counterfoils were completed in the certifying doctors handwriting. Dr Barton had a distinctive signature almost invariably written with black ink. Consequently, deaths she had certified could be readily and confidently identified. However, the signatures of the other doctors were generally less distinctive, and consequently it was not possible to reliably identify other doctors. The other doctors would have included general practitioners who had cared for patients admitted to general practitioner beds, and doctors attending patients of the Department of Medicine for Elderly People when Dr Barton was not on duty.

Results

1. Numbers of deaths

The numbers of certificates issued each year by Doctor Barton and other doctors are shown in Table 3.2.

Table 3.2. Numbers (%) of MCCD counterfoils each year, 1987-2000, completed by Dr Barton or other doctors at Gosport.

Year	Other docs	Dr Barton	Total
1987	105 (98.1)	2 (1.9)	107
1988	85 (74.6)	29 (25.4)	114
1989	71 (69.6)	31 (30.4)	102
1990	72 (65.5)	38 (34.5)	110
1991	59 (65.6)	31 (34.4)	90
1992	68 (68.0)	32 (32.0)	100
1993	57 (36.5)	99 (63.5)	156
1994	56 (34.6)	106 (65.4)	162
1995	74 (47.7)	81 (52.3)	155
1996	100 (54.3)	84 (45.7)	184
1997	106 (55.2)	86 (44.8)	192
1998	107 (50.0)	107 (50.0)	214
1999	71 (43.6)	92 (56.4)	163
2000	81 (70.4)	34 (29.6)	115
2001	103 (98.1)	2 (1.9)	105
Total	1214 (58.7)	854 (41.3)	2069

Between 1987 and 2001, Dr Barton completed 854 MCCDs, 41.3% of all those issued at the hospital. The numbers issued by Dr Barton rose from 1988, when she issued 25% of all those issued in the year, to 1994 when she issued 64% of the total. There was a rise in the total numbers coincident with the rise in proportion issued by Dr Barton, and it was not until 2000 when the total number returned to the levels typical of the years 1987-1992. Dr Barton issued two MCCDs in 2001 for patients

who had died in general practitioner beds, the year after the termination of her clinical assistant post.

2. Age and gender of deceased patients

The mean age of Dr Barton's deceased patients was 82.8 years, but for the other doctors the mean was 78.8 (t 9.31, df 1807, p<0.001). The difference in age is probably explained by the admission criteria for the different hospital wards. The gender of the deceased could be identified in 2033 (98.3%) of the 2069 cases, and among Dr Barton's patients 478 (56.8%) were female, in comparison with 623 (52.3%) among the other doctors (Chi Square 3.95, df 1, p 0.047).

3. Certified cause of death

The cause of death, grouped into the six categories as defined in Chapter Two, given by Dr Barton and other doctors are shown in Table 3.3.

Table 3.3: Numbers (%) of deaths certified as due to groups of conditions by Dr Barton and the other doctors (Chi Sq 507.9, df 5, p <0.001).

	Other docs	Dr Barton	
cancer	424 (38.6)	49 (5.8)	473
heart conditions	165 (15.0)	100 (11.8)	265
stroke	106 (9.7)	139 (16.4)	245
bronchopneumonia + other conditions	235 (21.4)	367 (43.3)	602
bronchopneumonia alone	21 (1.9)	162 (19.1)	183
other condition	147 (13.4)	31 (3.7)	178
total	1098	848	1946

Dr Barton's patients were less likely to have been certified as dying primarily because of cancer or heart conditions, but more likely to have died from bronchopneumonia with or without other conditions, or from strokes. Case mix will explain at least some of these differences. Thus, local general practitioners appear to have admitted patients with cancer to Gosport Hospital for terminal care, but Dr Barton was responsible for the care of other groups, including people with Alzheimer's disease or other forms of dementia, and those recovering from strokes or in need of rehabilitation for other reasons.

4. Deceased seen after death, and post-mortems

Dr Barton was more likely to have reported personally seeing the deceased after death (98.6% vs 86.9%, Chi Sq 89.3, df 2, $p<0.001$). Dr Barton reported that in 99.4% of deaths, no post mortem or referral to the coroner occurred; the proportion for the other doctors was 98.4%. These cases will not have included all cases reported to the coroner, since no MCCD would have been issued by the doctor in those cases that the coroner chose to investigate. In such cases, a certificate would be issued by the coroner at the conclusion of the coronial investigation. Therefore, the deaths indicated as referred to the coroner on the counterfoils are likely to include only those in which a discussion took place with the coroner or coroner's officer, and that concluded that an MCCD should be issued by the doctor.

5. Day, calendar quarter and week of death

The date of death was used to identify the day of week of death. In the case of both Dr Barton's patients and the patients whose deaths were certified by other doctors, the pattern was as expected, with approximately equal proportions of deaths occurring on each day of the week (Table 3. 4). A marginally greater proportion of Dr Barton's patients died during the winter (October to March), a factor that might be explained by seasonal factors influencing the types of conditions with which patients

were admitted, or because Dr Barton was more likely to take vacations between April and September (Table 3.5). Table 3.6 shows the distribution of deaths during the year when the certified cause of death was given as bronchopneumonia only. Dr Barton issued a greater number of certificates giving this cause of death, although the temporal distribution was no different to that of the other doctors.

Table 3.4. Numbers (%) of patients certified as dying on each day of the week (Chi Sq 5.1, df 6, not significant).

	doctor		total
	other doctors	Dr Barton	
1	174 (15.7)	113 (13.3)	287
2	147 (13.2)	111 (13.0)	258
3	154 (13.9)	122 (14.3)	276
4	151 (13.6)	137 (16.1)	288
5	139 (12.5)	117 (13.7)	256
6	176 (15.9)	132 (15.5)	308
7	169 (15.2)	119 (14.0)	288
	1110	851	1961

Table 3.5. Numbers (%) of patients certified as dying in each calendar quarter (Chi Sq 11.2, df 3, p < 0.01)

quarter	doctor		total
	Other doctors	Dr Barton	
Jan-Mar	269 (24.1)	235 (27.6)	504
Apr-Jun	288 (25.8)	199 (23.4)	487
Jul-Sep	294 (26.3)	182 (21.4)	476
Oct-Dec	266 (23.8)	236 (27.7)	502
	1117	852	1969

Table 3.6. Numbers (%) of deaths in different quarters certified as due to bronchopneumonia alone (Chi Sq 0.67, df 3, not significant).

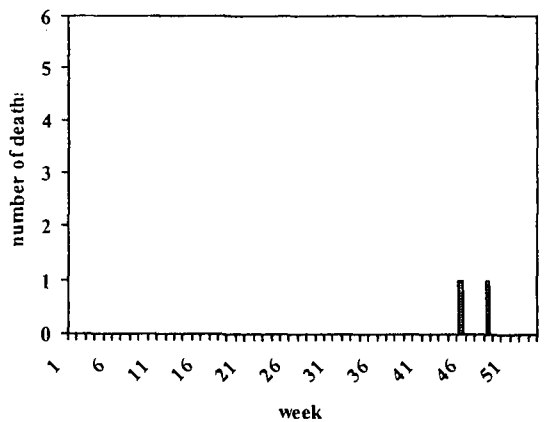
quarter	Doctor		total
	other doctors	Dr Barton	
Jan-Mar	7 (31.8)	51 (31.5)	58
Apr-Jun	6 (27.3)	33 (20.4)	39
Jul-Sep	3 (13.6)	28 (17.3)	31
Oct-Dec	6 (27.3)	50 (30.9)	56
	22	162	184

The distribution of deaths according to week of the year may also be used to identify clusters of deaths, and variations in the numbers of deaths at different times. Table 3.7 shows the mean number of deaths per week certified by Dr Barton from 1988 until July 2000, when she ceased employment at Gosport hospital. The findings demonstrate the increase in the numbers of deaths from 1993, the year in which Dryad and Daedalus wards were opened.

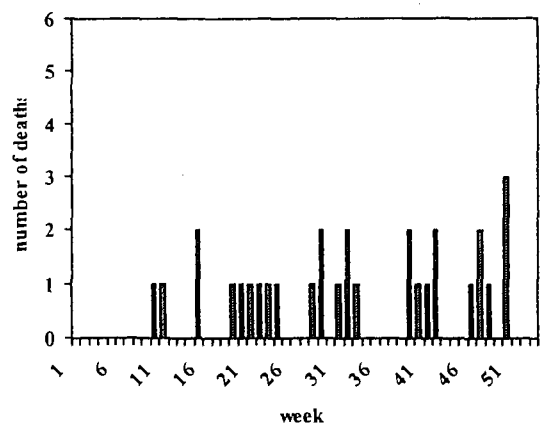
Table 3.7. Mean and standard deviation (SD) of numbers of deaths certified by Dr Barton per week, 1988- 2000.

year	minimum	maximum	number	mean	SD
1988	0	3	29	.53	.77
1989	0	2	31	.58	.69
1990	0	5	38	.72	.97
1991	0	3	31	.58	.89
1992	0	2	32	.60	.77
1993	0	5	99	1.87	1.43
1994	0	6	105	1.98	1.63
1995	0	6	81	1.53	1.31
1996	0	5	84	1.58	1.18
1997	0	6	86	1.62	1.40
1998	0	6	107	2.02	1.57
1999	0	6	92	1.74	1.32
2000	0	4	34	1.31	1.19

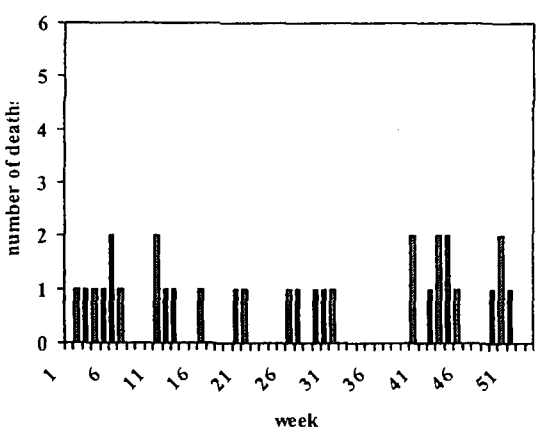
The Figures 3.1 to 3.15 in the following pages show the numbers of deaths certified each week from 1987 to 2001. They demonstrate the rise in the numbers of deaths from 1993 onwards, and suggest a decline in numbers may have occurred during 2000, although Dr Barton worked only until July in that year. The two deaths in 1987 would presumably have been for patients in general practitioner beds under the care of Dr Barton or one of her partners in her general practice. Other than the rise in numbers of deaths from 1993, the Figures do not indicate any clear clusters of deaths or patterns of concern.



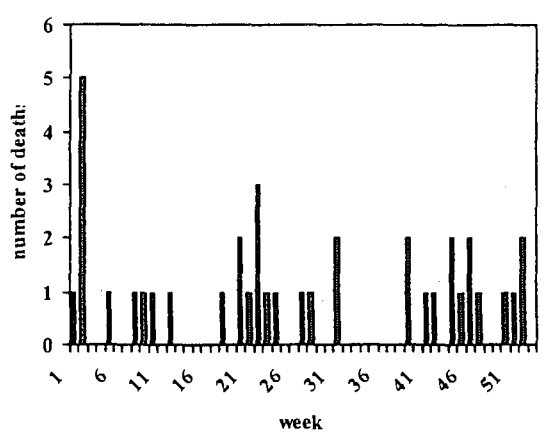
3.1. Deaths in 1987



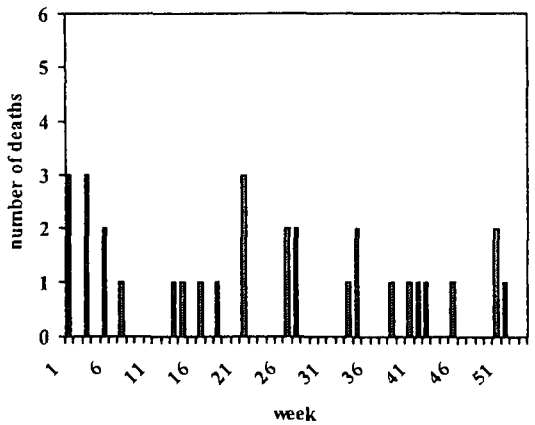
3.2. Deaths in 1988



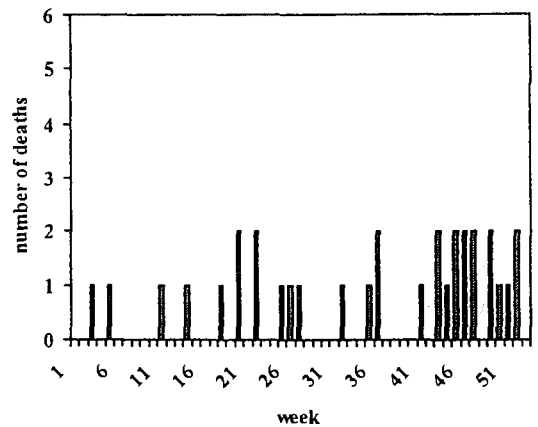
3.3. Deaths in 1989



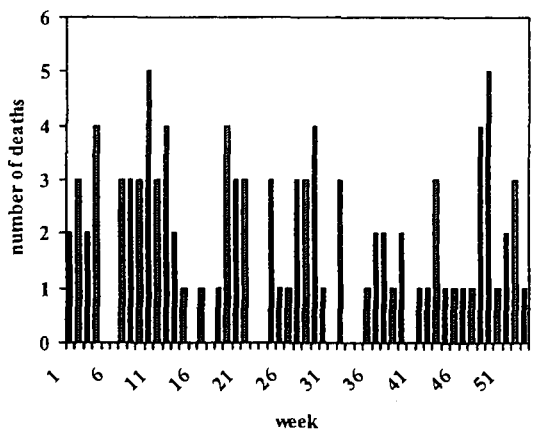
3.4. Deaths in 1990



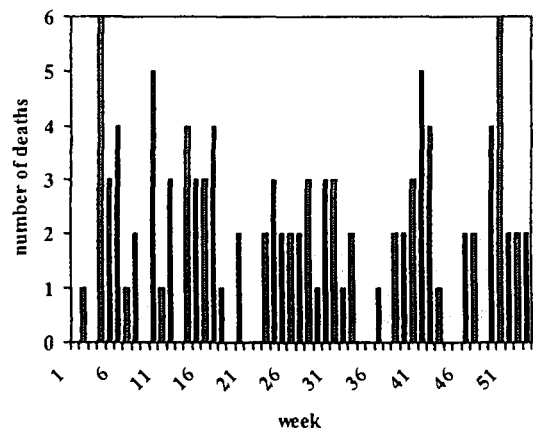
3.5. Deaths in 1991



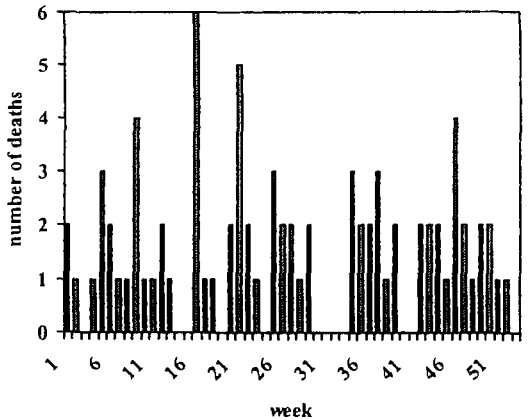
3.6. Deaths in 1992



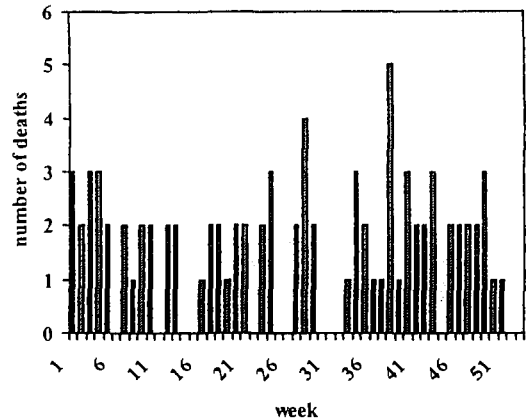
3.7. Deaths in 1993



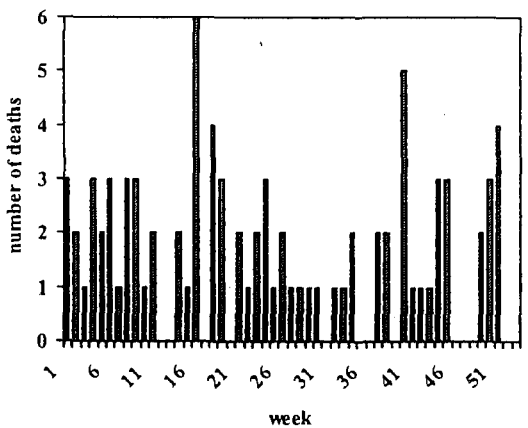
3.8. Deaths in 1994



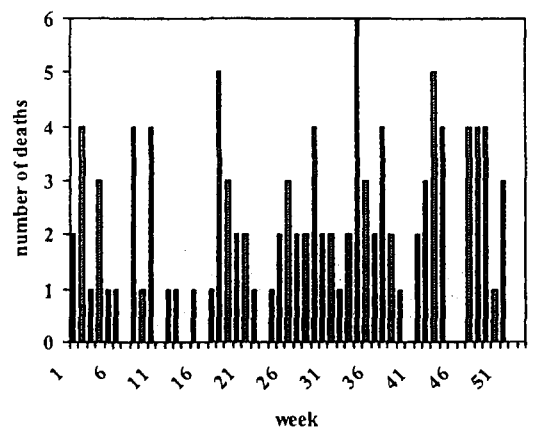
3.9. Deaths in 1995



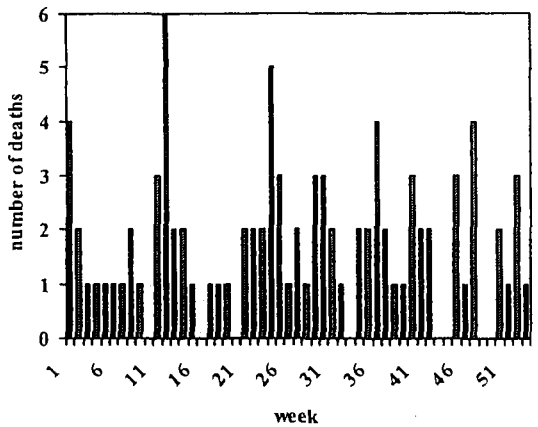
3.10. Deaths in 1996



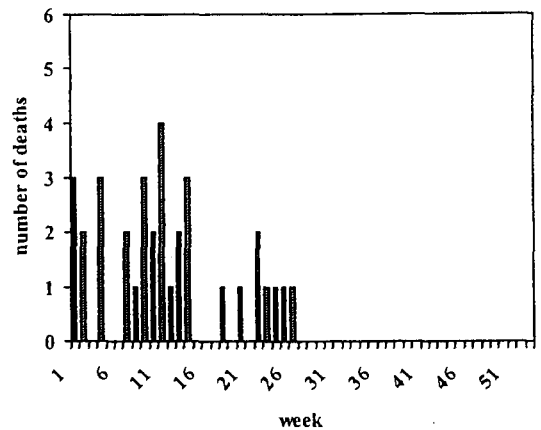
3.11. Deaths in 1997



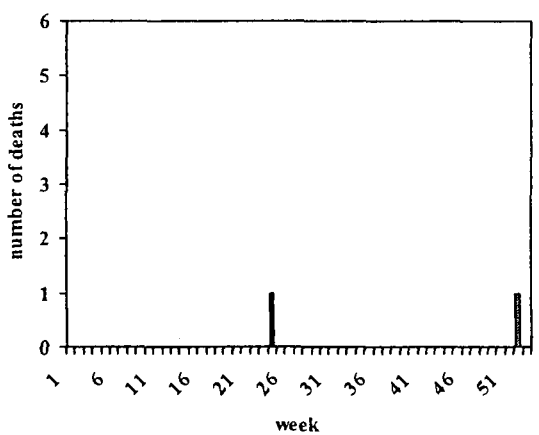
3.12. Deaths in 1998



3.13. Deaths in 1999



3.14. Deaths in 2000



3.15. Deaths in 2001

6. Patients on Dr Barton's wards

In some cases, doctors other than Dr Barton issued MCCDs for patients who died on wards specifically served by Dr Barton in her role as clinical assistant in the Department of Medicine for Elderly People. These wards were Redclyffe Annexe, and Dryad and Daedalus wards. Dr Barton also cared for some patients in the male and female wards, but these wards were not exclusive to patients of the Department. The completion of MCCDs by other doctors for patients in Redclyffe Annexe, or Dryad and Daedalus wards, could occur principally when Dr Barton was on leave or not on duty. Therefore, the case mix of these patients would tend to be similar to those whose deaths were certified by Dr Barton.

Tables 3.8 and 3.9 show respectively the certificates issued by the other doctors at the hospital and Dr Barton for deaths on different wards. These data reflect the fact that Dr Barton ceased responsibility for patients in Redclyffe Annexe and took on the new Dryad and Daedalus wards 1993/4.

Table 3.8. Deaths certified by doctors other than Dr Barton on wards at Gosport (Mulberry is a 40 bed assessment unit).

year	place of death								
	Gosport (ward not stated)	*Redclyffe*	*male ward*	*female ward*	*Daedalus ward*	*Dryad ward*	*Sultan ward*	*Mulberry*	*tota*
1987	66	9	9	11					95
1988	61	3	13	5					82
1989	52	3	3	10					68
1990	52	2	9	9					72
1991	37	1	10	11					59
1992	35	1	16	15					67
1993	34	2	3	6	3		8		56
1994	15	5			2		33		55
1995	12				12	5	35	10	74
1996	28	7			10	6	37	11	99
1997	10	3			8	7	45	33	100
1998	23	5			12	11	35	18	93
1999	12	7			6	9	27	10	71
2000	20	5			13	12	22	9	81
2001	59	8			1	4	25	6	103
	523	61	63	67	67	54	267	97	1175

Table 3.9. Deaths certified by Dr Barton on different wards at Gosport.

year	place of death							Total
	Gosport (ward not stated)	*Redclyffe*	*male ward*	*female ward*	*Daedalus ward*	*Dryad ward*	*Sultan ward*	
1987	1	1						2
1988	2	6	11	1				20
1989	1	19	8	1				29
1990		23	13	2				38
1991		18	11	2				31
1992		23	8	1				32
1993		51	7	6	35			99
1994		58	1		42		4	105
1995	1	4			42	33	1	81
1996					48	32	3	83
1997					39	47		86
1998					51	51	5	107
1999					42	49	1	92
2000					15	17	2	34
2001						1	1	2
	5	203	59	13	314	230	17	841

The mean age of patients who died on each ward was different (Table 3.10). Patients in Redclyffe, Daedalus and Dryad wards tended to be older than those in the other wards. Greater proportions of patients who died in Redclyffe, Daedalus and Dryad wards were female than those who died in Sultan ward (Table 3.11).

Table 3.10. Mean age (years) of patients who died in different wards. (N=1799, p <0.005)

Ward	number	mean age	95 % confidence intervals
Gosport hospital, ward not specified	427	78.4	77.4 – 79.4
Redclyffe	250	82.8	81.8 – 83.7
Male ward	109	78.1	76.4 – 79.9
Female ward	68	80.3	77.7 – 82.8
Daedalus	381	82.5	81.8 – 83.2
Dryad	284	83.7	82.9 – 84.5
Sultan	280	77.0	75.6 – 78.4

Table 3.11. Numbers (%) of males and females who died in wards in Gosport hospital.

ward	gender		total
	male	*female*	
Gosport, ward not stated	244 (47.8)	266 (52.2)	510
Redclyffe	68 (26.2)	192 (73.8)	260
male ward	115 (96.6)	4 (3.4)	119
female ward		78 (100.0)	78
Daedalus ward	173 (46.1)	202 (53.9)	375
Dryad Ward	135 (47.7)	148 (52.3)	283
Sultan Ward	142 (51.1)	136 (48.9)	278
total	877 (46.1)	1026 (53.9)	1903

7. Certified cause of death

The certified cause of death could be determined from 2052 (99.2%) of the 2069 counterfoils available. Table 3.12 shows, for all deaths regardless of place of death in Gosport Hospital, the numbers of deaths certified as primarily due to one of six groups of conditions. Dr Barton was more likely to give bronchopneumonia or stroke as the cause of death (Chi sq 529.6, df 5, P< 0.001). A potential explanation is case mix – patients with dementia or stroke would have been admitted to Redclyffe, Dryad and Daedalus wards. Another possibility is excess use of sedative medication, leading to development of bronchopneumonia.

Table 3.12. Cause of death in groups, according to whether Dr Barton or other doctors signed the certificate.

Cause of death	Other doctors	Barton	total
cancer	460 (38.3)	50 (5.9)	510
heart	172 (14.3)	100 (11.8)	272
stroke	112 (9.3)	139 (16.4)	251
bronchopneumonia plus another	263 (21.9)	368 (43.3)	631
bronchopneumonia only	22 (1.8)	162 (19.1)	184
other	173 (14.4)	31 (3.6)	204
	1202	850	2052

It was possible to identify from the counterfoils 946 patients who had died in Daedalus, Dryad and Sultan wards. The admission criteria for these wards were different, and this is reflected in the differences in the certified causes of death among patients who died in these wards (Table 3.13). Since Dr Barton was responsible for patients in Daedalus and Dryad wards, and general practitioners were responsible for patients in Sultan ward, it is possible that the differences observed in the certified causes of deaths between these doctors would be at least partly explained by the different characteristics of the patients they cared for.

Table 3.13. Numbers (%) of deaths certified as due to different causes on Daedalus, Dryad and Sultan wards (Chi Sq 344.8, df 10, p<0.005).

	ward			total
	Daedalus ward	*Dryad ward*	*Sultan ward*	
cancer	21 (5.5)	24 (8.5)	158 (56.0)	203
heart	51 (13.4)	37 (13.0)	36 (12.8)	124
stroke	95 (25.0)	29 (10.2)	10 (3.5)	134
bronchopneumonia plus another	135 (35.5)	103 (36.3)	44 (15.6)	282
bronchopneumonia only	56 (14.7)	65 (22.9)	13 (4.6)	134
other	22 (5.8)	26 (9.2)	21 (7.4)	68
	380	284	282	946

There were also variations in the certified causes of death according to the gender of patients, cancer being less frequently given as the cause of death among males, and bronchopneumonia alone more frequently among females (Table 3.14). However, this difference was not apparent when the analysis was confined to patients whose deaths had been certified by doctors other than Dr Barton (Table 3.15).

Table 3.14. Numbers (%) of male and female patients certified as dying due to certain causes (Chi Sq 19.8, df 5, p<0.001)

cause of death	gender		total
	male	*female*	
cancer	244 (28.0)	241 (23.6)	485
heart	114 (13.1)	137 (13.4)	251
stroke	104 (12.0)	129 (12.6)	233
bronchopneumonia plus another	278 (32.0)	305 (29.9)	583
bronchopneumonia only	57 (6.6)	124 (12.1)	181
other	73 (8.4)	85 (8.3)	158
	870 (100.0)	1021 (54.0)	1891

Table 3.15. Numbers (%) of male and female patients certified by doctors other than Dr Barton as dying due to certain causes (Chi 3.9, df 5, not significant).

cause of death	gender		total
	male	*female*	
cancer	218 (42.7)	219 (39.5)	437
heart	66 (12.9)	91 (16.4)	157
stroke	44 (8.6)	53 (9.5)	97
bronchopneumonia plus another	113 (22.2)	112 (20.2)	225
bronchopneumonia only	9 (1.8)	12 (2.2)	21
other	60 (11.8)	68 (12.3)	128
	510 (100.0)	555 (100.0)	1065

A comparison between certificates issued by Dr Barton and the other doctors restricted to selected wards would reduce the likelihood that case mix would explain any observed differences. From 1987, 745 MCCDs were issued by Dr Barton and 166 by other doctors for patients in Redclyffe Annexe and Daedalus and Dryad wards. The mean age of the patients was similar (Dr Barton 83.0, the other doctors 82.5, not significantly different), as would be expected if the case mix had been the same. Among Dr Barton's patients, 439 (59.5%) were females, and among the patients of the other doctors 103 (57.2%) were females (difference not statistically significant). However, the other doctors gave bronchopneumonia alone as the cause of death in only 3% of cases, but among Dr Barton's patients the proportion was 20% (Chi Square 88.3, df 5, p 0.000) (Table 3.16).

Table 3.16. Causes of death among patients of Redclyffe Annexe, Daedalus and Dryad Wards, 1987-2001, comparing those certified by Dr Barton and other doctors.

cause of death	**ward**					
	Redclyffe		Daedalus ward		Dryad ward	
	other	*Dr Barton*	*other*	*Dr Barton*	*other*	*Dr Barton*
cancer	3 (5.9)	2 (1.0)	6 (9.2)	14 (4.5)	5 (10.0)	18 (7.9)
heart	7 (13.7)	12 (5.9)	11 (16.9)	40 (12.7)	6 (12.0)	31 (13.5)
stroke	8 (15.7)	23 (11.4)	18 (27.7)	77 (24.5)	4 (8.0)	25 (10.9)
bronchopneumonia plus another	23 (45.1)	125 (61.9)	17 (26.2)	118 (37.6)	19 (38.0)	84 (36.7)
bronchopneumonia only		36 (17.8)	1 (1.5)	55 (17.5)	4 (8.00)	58 (25.3)
other	10 (19.6)	4 (2.0)	12 (18.5)	10 (3.2)	12 (24.0)	13 (5.7)
	51	202	65	314	50	229

8. Hospital Episode Statistics

To determine whether there were a greater number of deaths than would have been expected among patients admitted to Gosport under the care of the Department of Medicine for Elderly People, a method is required for estimating the numbers of deaths that would have been expected. Since Gosport hospital is a community hospital, a comparison with other community hospitals would be a logical approach.

Information on admitted patient care delivered by NHS hospitals from 1989 is provided by Hospital Episode Statistics (HES), and HES were requested to provide information for this review. HES employs a coding system, each patient episode being assigned a series of codes that indicate the hospital in which care was provided, the type of speciality concerned, and the diagnosis. The codes are entered into a database in each NHS hospital, and the information is then collated at a national level by the Department of Health.

In order to identify those patients who were cared for in the Department of Medicine for Elderly People in Daedalus and Dryad wards at Gosport, specific codes indicating the speciality, hospital and ward would have been desirable. However, HES at a national level records information by hospital trust, but not necessarily by local hospital or specific ward. Thus, the national data do not allow the ready identification of patients who were cared for in the two wards at Gosport that are the focus of this review. Episode statistics that identified the ward were, however, available at Gosport hospital, but only relating to the years 1998 onwards. Consequently, data about most of the years of interest were not available.

Even if complete data for all the years of interest had been available, the difficulties would not have been resolved. The reason for employing HES data is to enable comparisons between the mortality rates in Gosport hospital with those of similar community hospitals elsewhere who were caring for similar groups of patients over the same period. The level of detail in the central HES data does not, however, permit the identification of a satisfactory group of comparable community hospitals and similar group of patients. For example, even when HES codes are selected that identify patients who have been transferred between hospitals following initial admission because of a stroke, the mortality rate (approximately 30%) is substantially lower than that in Gosport (see Table 4.3). An uncritical acceptance of this finding would lead to the conclusion that patients admitted to Gosport were more likely to die than if they had been admitted elsewhere, whereas in fact the patients who were admitted to Gosport were more severely ill than those in the best comparison group yet identified from the central HES data. The collection of episode statistics directly from a sample of community hospitals would ensure that more detailed information would be obtained. However, since a comparison would only be possible from 1998, and it would be impossible to eliminate the effects of case-mix among patients admitted to different hospitals, it would be impossible to place much confidence on the findings of such a comparison. Consequently, an analysis using HES data has not been undertaken in this review.

Discussion

Two points about the use of counterfoils as a source of data should be discussed first.

1) identification of all deaths

In this analysis of deaths identified from the counterfoils of MCCDs stored at Gosport hospital, some deaths may not be included, for example deaths referred to the coroner; in a few cases the doctor may not have issued the certificate from the Gosport hospital certificate book. However, a comparison with the numbers of certificates for deaths at the hospital completed by Dr Barton and certificates identified by National Statistics shows the number to be virtually identical (Tables 3.1 and 6.1), and therefore the data from counterfoils are likely to be sufficiently complete to permit conclusions to be drawn.

2) completion of counterfoils

The writing of some doctors was difficult to read, and the signatures of many could not be interpreted. However, the counterfoils completed by Dr Barton were easily identified. She had bold and confident handwriting, and used distinctive black ink. Also, occasional counterfoils were not fully completed, although this problem was uncommon and will not have influenced the findings of the analysis. Although Dr Barton usually specified the ward in which patients had died, other doctors often gave less detail and usually only indicated Gosport hospital as the place of death. However, this lack of detail is unlikely to have been systematic, and therefore it is possible to be reasonably confident in the findings of the comparison between deaths in different wards.

Findings

The analysis has identified the following concerns:

1. In her role as clinical assistant in the Department of Medicine for Elderly People, Dr Barton issued a large number of MCCDs between 1987 and 2000. Between 1988 and 1992, the numbers were between 29 and 38 per year, but from 1993 the numbers increased to between 81 and 107 per year, falling to 34 in 2000, the year in which Dr Barton left the hospital in July. Dryad and Daedalus wards

opened in 1993-4, a factor that is likely to explain the increase in numbers of deaths in these years owing to differences in the types of patients admitted to these wards. Patients in Redclyffe Annexe commonly suffered from dementia, but those admitted to Dryad and Daedalus had a wider range of severe clinical problems.

2. The proportion of deaths certified by either Dr Barton or other doctors occurring on each day of the week was more or less the same. In comparison with other doctors, Dr Barton issued a lower proportion of MCCDs during the summer months, but this finding is likely to be explained by annual leave being taken during the summer months.
3. The case mix of patients is likely to explain most of the observed differences between MCCDs issued by Dr Barton and those issued by other doctors. For example, patients under her care tended to be older than patients whose deaths were certified by other doctors.
4. It is notable that the patients admitted to Sultan ward, under the care of their general practitioners, were more likely to have been certified as dying due to cancer. They were also younger than patients who had died in Daedalus and Dryad wards.
5. The effect of case mix is probably reduced in an analysis that compared deaths in Redclyffe Annexe, Daedalus and Dryad wards that had been certified by Dr Barton or by other doctors. In this analysis, the mean age and proportion who were female was similar. However, Dr Barton gave bronchopneumonia alone as the cause of death significantly more frequently than the other doctors. The review of records (Chapter Two) highlighted that patients who had been certified as having died of bronchopneumonia had had other significant conditions, including recent fractures of the hip. Furthermore, a high proportion of these patients had received opiates before death. Consequently, although case mix

almost certainly explains much of the difference between patients in the Department of Medicine for Elderly People managed by Dr Barton and those under the care of other general practitioners, concerns about the use of opiates and the possible contribution they may have made to the deaths of some patients cannot be ruled out.

Chapter Four: Admissions to Dryad Ward

Introduction

The admissions book for Dryad ward has been retained by the hospital, and contained information about all admissions from 1993, the year of first opening of the ward. The information recorded in the book included dates of admission and discharge (or death), the time of day of deaths, some indication of the reasons for admission, and the place the patient had been admitted from. This information was studied in order to identify the characteristics of patients admitted to Dryad ward, and aspects of the care they had received.

It should be noted that Daedalus ward did not have a similar book, although a day-book appears to have been employed. This did not contain information helpful to this review.

Methods

There had been a total of 715 admissions from the opening of the ward in 1993 until the end of 2001. The admissions book recorded the date of admission and the date of discharge or death, and it was therefore possible to calculate the length of admission. Table 4.1 shows the mean length of admissions by year of admission, for the 676 (94.5%) admissions in which the admission and discharge date could be identified. There was some variation between years, with admissions during 1998 having the shortest mean length.

Table 4.1. Mean length (days) of stay on Dryad ward, days, 1993-2001.

year	number of admissions	mean (days)	95% CI for mean		minimum	maximum
			Lower	Upper		
1993	37	148.6	87.6	209.5	4	652
1994	68	41.7	24.7	58.7	1	326
1995	52	88.8	41.9	135.6	1	856
1996	43	56.0	33.6	78.3	1	345
1997	67	33.9	19.3	48.6	1	365
1998	103	36.0	28.1	43.9	0	195
1999	131	42.5	32.4	52.6	0	406
2000	90	65.8	47.4	84.2	1	487
2001	85	67.5	48.5	86.6	4	409
Total	676	57.1	50.0	64.1	0	856

The mean age of patients on admission to Dryad ward is shown in Table 4.2, according to year of admission, for the 708 (99.0%) cases in which the patient's age could be identified. There was no significant difference between years. The admissions book did not record the gender of patients, but gender could be inferred from the names of 712 (99.5%) of the 715 cases. Of these 414 (58.1%) were female.

Table 4.2. Mean age (yrs) at admission to Dryad ward, 1993-2001.

year	number of admissions	mean (yrs)	95% CI for mean		minimum	maximum
			Lower	Upper		
1993	38	82.1	79.7	84.4	66.0	97.0
1994	75	83.7	82.0	85.3	64.4	100.0
1995	56	82.6	80.6	84.5	66.9	99.0
1996	45	83.0	81.0	84.9	69.8	95.2
1997	71	81.8	79.9	83.8	66.3	98.0
1998	105	83.2	81.7	84.6	67.1	100.0
1999	133	83.6	82.3	84.8	65.0	98.2
2000	89	82.7	81.2	84.2	67.0	100.0
2001	96	80.9	79.2	82.6	61.0	100.0
Total	708	82.7	82.1	83.21	61.0	100.0

The Dryad ward admissions book recorded whether the patient died or was discharged. Table 4.4 indicates that the proportion of patients who were discharged

alive was less than 50% until 1999. Between 1993-5, 80% of admitted patients died on the ward.

Table 4.3. Numbers (%) of admissions followed by death or discharge, Dryad ward, 1993-2001.

year	Outcome		Total
	died	discharged	
1993	29 (80.6)	7 (19.4)	36
1994	59 (84.3)	11 (15.7)	70
1995	42 (80.8)	10 (19.2)	52
1996	31 (70.5)	13 (29.5)	44
1997	48 (69.6)	21 (30.4)	69
1998	64 (61.5)	40 (38.5)	104
1999	58 (43.9)	74 (56.1)	132
2000	35 (38.5)	56 (61.5)	91
2001	39 (45.3)	47 (54.7)	86
	405	279	684

The causes of death of patients of Dryad certified by Dr Barton are shown in Table 4.4. These data were taken from the MCCD counterfoils (see Chapter Three).

Table 4.4. Deaths on Dryad ward certified by Dr Barton

Cause of death							Total
	cancer	*heart*	*stroke*	*bronchopneumonia plus another*	*bronchopneumonia only*	*other*	
1995	2	4	2	15	8	1	32
1996	1	3	5	17	5	1	32
1997	2	11	4	23	6	1	47
1998	3	4	6	15	18	5	51
1999	7	6	5	12	15	4	49
2000	3	2	3	2	6	1	17
2001					1		1
	18	30	25	84	59	13	229

The admissions book recorded brief information about the patient's illnesses at the time of admission. On a few occasions, this information included an indication of the reason for admission, for example respite care. Table 4.5 summarizes the findings. Medical/mental problems refer in the Table to either dementia or a mix of medical conditions with the additional problem of confusion or dementia; "post-op" indicates people who have had a recent operation, most commonly surgery following a fractured hip.

Table 4.5. Numbers (%) cases admitted to Dryad ward with different primary problems, 1993-2001.

Year	Diagnostic group							Total
	stroke	*general medical problems*	*medical/ mental problems*	*heart problems*	*Cancer*	*post op*	*respite care/social admission*	
1993	9 (23.7)	19 (50.0)	6 (15.8)	2 (5.3)	2 (5.3)			38
1994	10 (13.5)	31 (41.9)	14 (18.9)	2 (2.7)	3 (4.1)	14 (18.9)		74
1995	7 (12.5)	23 (41.1)	13 (23.2)		7 (12.5)	5 (8.9)	1 (1.8)	56
1996	1 (2.5)	20 (50.0)	10 (25.0)		7 (17.5)	2 (5.0)		40
1997	4 (5.7)	29 (41.4)	16 (22.9)	5 (7.1)	8 (11.4)	8 (11.4)		70
1998	6 (5.8)	42 (40.4)	11 (10.6)	3 (2.9)	9 (8.7)	23 (22.1)	10 (9.6)	104
1999	10 (7.6)	47 (35.9)	10 (7.6)	6 (4.6)	11 (8.4)	38 (29.0)	9 (6.9)	131
2000	8 (9.0)	38 (42.7)	8 (9.0)	2 (2.2)	10 (11.2)	20 (22.5)	3 (3.4)	89
2001	11 (12.4)	30 (33.7)	16 (18.0)	1 (1.1)	8 (9.0)	9 (10.1)	14 (15.7)	89
Total	66	279	104	21	65	119	37	691

General medical problems were the commonest reason for admission in all years, but the proportion of admissions for other problems varied. Stroke was a relatively common reason for admission in 1993, and dementia with or without other medical problems was also relatively common until 1998. The proportion of patients who had been admitted following surgery increased from 1998, as did admissions for respite care.

The admissions book also recorded information about the source of admission. This information is summarised in Table 4.6. Dolphin Day Hospital is the day hospital based in Gosport War Memorial Hospital.

Table 4.6. Sources of admission to Dryad ward, 1993-2001.

year	home	rest/nursing home	acute hospital	Sultan ward	another ward at Gosport	Dolphin day hospital	
1993	4 (10.5)	2 (5.3)	23 (60.5)	8 (21.1)	1 (2.6)		38
1994	8 (10.7)	2 (2.7)	56 (74.7)	8 (10.7)	1 (1.3)		75
1995	6 (10.9)	2 (3.6)	42 (76.4)	3 (5.5)	1 (1.8)	1 (1.8)	55
1996	2 (4.4)	4 (8.9)	36 (80.0)	2 (4.4)	1 (2.2)		45
1997	3 (4.2)		56 (78.9)	7 (9.9)	3 (4.2)	2 (2.8)	71
1998	13 (12.4)		82 (78.1)	4 (3.8)	5 (4.8)	1 (1.0)	105
1999	19 (14.4)	2 (1.5)	103 (78.0)	1 (0.8)	4 (3.0)	3 (2.3)	132
2000	8 (8.8)	1 (1.1)	76 (83.5)	1 (1.1)	4 (4.4)	1 (1.1)	91
2001	23 (24.5)	2 (2.1)	49 (52.1)	8 (8.5)	12 (12.8)		94
Total	86	15	523	42	32	8	706

Most patients admitted to Dryad ward had been transferred from acute hospitals. Only in 2001 did the proportion of admissions directly from home approach 25%, a finding that is likely to be partly explained by the increase in admissions for respite care (Table 4.5).

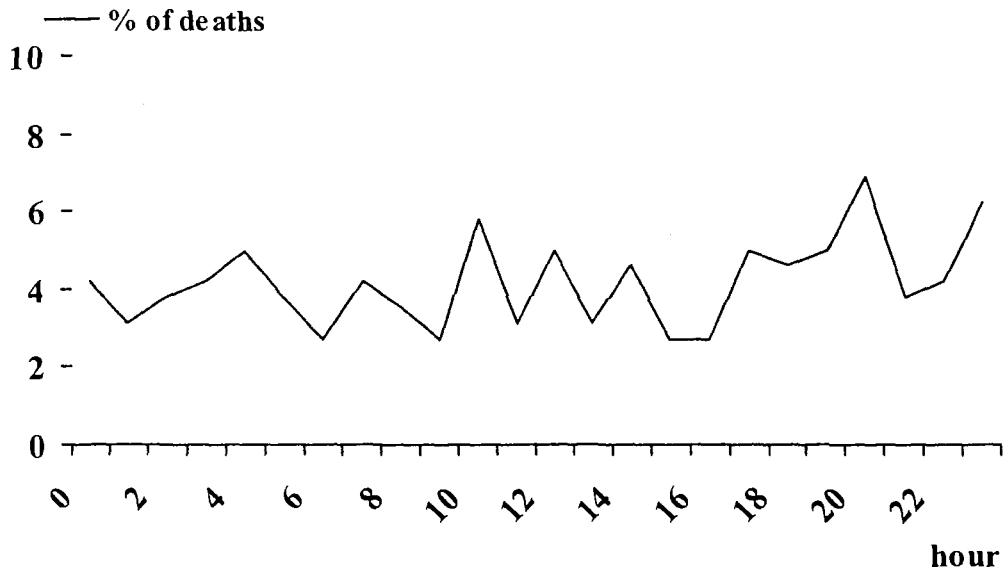
The time of death had been recorded in the admissions book in 260 cases (64.2% of the 405 deaths on the ward). Deaths are reasonably equally distributed among hours of the day (Table 4.7 and Figure 4.1).

Table 4.7. Time of death (data recorded in only cases only).

hour	year of admission									total
	1993	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	
0	1 (5.0)	4 (11.4)		1 (5.9)	1 (3.3)			4 (15.4)		11 (4.2)
1	1 (5.0)	2 (5.7)	2 (6.7)	1 (5.9)		1 (2.3)			1 (4.3)	8 (3.1)
2	1 (5.0)	1 (2.9)	3 (10.0)		1 (3.3)	2 (4.5)	1 (2.9)	1 (3.8)		10 (3.8)
3	1 (5.0)	1 (2.9)			1 (3.3)	2 (4.5)	5 (14.3)	1 (3.8)		11 (4.2)
4		3 (8.6)	2 (6.7)		2 (6.7)	1 (2.3)	3 (8.6)	1 (3.8)	1 (4.3)	13 (5.0)
5	1 (5.0)		1 (3.3)	1 (5.9)	2 (6.7)	2 (4.5)		2 (7.7)	1 (4.3)	10 (3.8)
6			1 (3.3)		2 (6.7)	3 (6.8)			1 (4.3)	7 (2.7)
7	1 (5.0)	2 (5.7)	2 (6.7)	1 (5.9)	3 (10.0)		1 (2.9)	1 (3.8)		11 (4.2)
8		2 (5.7)	1 (3.3)	2 (11.8)	1 (3.3)				3 (13.0)	9 (3.5)
9	1 (5.0)				1 (3.3)	3 (6.8)	1 (2.9)		1 (4.3)	7 (2.7)
10	1 (5.0)	3 (8.6)	1 (3.3)		2 (6.7)	5 (11.4)	2 (2.7)		1 (4.3)	15 (5.8)
11	2 (10.0)		1 (3.3)	1 (5.9)	1 (3.3)	1 (2.3)	1 (2.9)		1 (4.3)	8 (3.1)
12			2 (6.7)	2 (11.8)	4 (13.3)	2 (4.5)		2 (7.7)	1 (4.3)	13 (5.0)
13		3 (8.6)		2 (11.8)	1 (3.3)	2 (4.5)				8 (3.1)
14	2 (10.0)	1 (2.9)			1 (3.3)	3 (6.8)	1 (2.9)	3 (11.5)	1 (4.3)	12 (4.6)
15		1 (2.9)	1 (3.3)		2 (6.7)		2 (5.7)	1 (3.8)		7 (2.7)
16						1 (2.3)	2 (5.7)	2 (7.7)	2 (8.7)	7 (2.7)
17	1 (5.0)	1 (2.9)	2 (6.7)	1 (5.9)	1 (3.3)	2 (4.5)	2 (5.7)	1 (3.8)	2 (8.7)	13 (5.0)
18		2 (5.7)	2 (6.7)	2 (11.8)		1 (2.3)	3 (8.6)	2 (7.7)		12 (4.6)
19	4 (20.0)	1 (2.9)	2 (6.7)	1 (5.9)		1 (2.3)	3 (8.6)		1 (4.3)	13 (5.0)
20	1 (5.0)	2 (5.7)	3 (10.0)	2 (11.8)		1 (2.3)	3 (8.6)	3 (11.5)	3 (13.0)	18 (6.9)
21		1 (2.9)			2 (6.7)	3 (6.8)	2 (5.7)		2 (8.7)	10 (3.8)
22	1 (5.0)	2 (5.7)	2 (6.7)		1 (3.3)	3 (6.8)	1 (2.9)	1 (3.8)		11 (4.2)
23	1 (5.0)	3 (8.6)	2 (6.7)		1 (3.3)	5 (11.4)	2 (5.7)	1 (3.8)	1 (4.3)	16 (6.2)

Total	20	35	30	17	30	44	35	26	23	260

Figure 4.1. The percentage of deaths on Dryad ward, 1993-2001, in each hour of the day (n=260).



Discussion

Some qualifications about the admissions book as a source of date must be noted. There were occasional errors in the book, for example the admissions of some patients had not been entered on the day of admission, and some information was occasionally missing, for example the source of admission. Nevertheless, the book was generally complete, and can be assumed to represent a reasonable description of admissions throughout the period.

The information from the admissions book reveals a changing pattern of cases being admitted to Dryad ward. Most patients were admitted from acute hospitals and with general medical problems, dementia or after surgery. However, from 1998, the proportion with dementia decreased, and there were increases in the proportions of admissions that were for respite care or following surgery. These changes in case

mix are important when interpreting changes in mortality. The proportions of admissions that ended in death declined from 1997. However, the annual number of admissions increased, and consequently the total numbers of deaths did not decrease until 2000. It is not possible to describe in detail the changes in case mix of patients admitted to Daedalus and Sultan wards, but it is almost certain that changes did occur. There may also have been changes in case mix in the period 1988 – 1993 with respect to admissions to Redclyffe Annexe, and the male and female wards. If follows that any comparisons in mortality rates between those in the wards of the Department of Medicine for Elderly People at Gosport or between Gosport and other community hospitals must be interpreted with considerable caution.

More or less similar proportions of patients died in each hour, as would normally be expected. The finding of a predictable distribution of deaths throughout the hours of the day serves to reduce concern about the possibility of sudden death following the administration of lethal drug doses.

Chapter Five: Prescribing of opiate drugs

Introduction

Many of the concerns about deaths at Gosport War Memorial Hospital relate to the use of opiates. The misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 1985 stipulate that registers are kept of the administration of opiate drugs such as diamorphine, morphine and fentanyl. Registers must be bound, and entries must be in chronological order. This Chapter describes an investigation of the information contained in the controlled drug registers retained at Gosport Hospital.

Method

The surviving controlled drugs registers used at the hospital were obtained and reviewed. The relevant registers that were still available are shown in Table 5.1. No data were available from the male ward. Comparisons between wards were possible for some years, although the data were not always complete.

The controlled drug registers contained a record of every dose of opiate drug administered to each patient. It was possible to identify the first and last doses of each drug administered, and the quantity of drug in each dose.

Table 5.1. The periods for which controlled drug registers from different wards were available.

Ward	Dryad	Daedalus	Sultan	Redclyffe	Female ward	Male ward
Period covered by registers	25.6.95 – 5.3.02	6.10.96 – 14.8.02	13.7.94 – 31.10.01	27.2.93 – 28.10.95	30.8.87 – 8.9.94	No register available

Results

1. Numbers of patients who died who received opiates

Information was available from both the MCCD counterfoils (see Chapter Three) and the controlled drug registers, and it was possible to identify those who had received opiates during their final illness by matching counterfoils and register entries. The years 1997-2000 were selected, since the controlled drug register data from Dryad, Daedalus and Sultan were complete for this period. Table 5.2 shows the numbers and proportions of cases given an opiate before death, according to whether the MCCD was signed by Dr Barton or another doctor. A greater proportion of patients of Dr Barton received an opiate (Chi Square = 30.1; df 1, p <0.001).

Table 5.2. Numbers (%) of patients dying 1997-2000 who were prescribed at least one dose of an opiate before death.

Doctor signing MCCD	Opiate prescribed		Total
	yes	*no*	
Dr Barton	211 (74.0%)	74 (26.0%)	285
Another doctor	146 (51.8%)	136 (48.2%)	282
Total	357 (63.0%)	210 (37.0%)	567

Dr Barton was more likely to prescribe an opiate to patients who were certified as dying from bronchopneumonia with other conditions, bronchopneumonia alone, or other conditions (Table 5.3). In the Table, all the certified causes of death have been grouped into the six categories employed in Chapters Two and Three.

Table 5.3. The numbers (%) of patients dying 1997-2000 from groups of conditions who had been prescribed an opiate by Dr Barton or other doctors.

Cause of death	doctor	opiate		total	Sig (df 1)
		yes	*no*		
Cancer	Barton	15 (68.2%)	7 (31.8%)	22	0.2
	Another	78 (80.4%	19 (19.6%)	97	
Heart	Barton	26 (59.1%)	18 (40.9%)	44	0.58
	Another	11 (36.7%)	19 (63.3%)	30	
Stroke	Barton	37 (69.8%)	16 (30.2%)	53	0.19
	Another	16 (55.2%)	13 (44.8%)	29	
bronchopneumonia with other conditions	Barton	64 (76.2%)	20 (23.8%)	84	0.001
	Another	27 (37.5%)	45 (62.5%)	72	
bronchopneumonia only	Barton	57 (83.8%)	11 (16.2%)	68	0.01
	Another	3 (42.9%)	4 (57.1%)	7	
other conditions	Barton	12 (85.7%)	2 (14.3%)	14	0.001
	Another	10 (21.7%)	36 (78.3%)	46	

The analysis in Table 5.3 was repeated for all deaths that occurred in Redclyffe Annexe up to and including 1994. Patients in the Annexe were generally the elderly mentally infirm, and Dr Barton was the responsible doctor at the Annexe until approximately 1994 (see Table 3.9). The findings do not indicate differences in use of opiates between Dr Barton and the other doctors, although none of the other doctors gave bronchopneumonia alone as the cause of death in this period. However, a comparison involving deaths in Redclyffe from 1995 indicates leads to different findings. None of the patients whose deaths were certified by other doctors had received an opiate, although all three of those certified by Dr Barton had (Table 5.5). A test of statistical significance has not been performed since the numbers of cases involved was small. However, there does appear to have been a change in the use of opiates at the end of life at about the time Dr Barton ceased to have principal

Table 5.4. The numbers (%) of patients dying 1993-1994 in Redclyffe Annexe from different causes who were prescribed an opiate by Dr Barton or other doctors.

Cause of death	doctor	opiate		total	sig
		Yes	no		
Cancer	Barton	1 (50.0)	1 (50.0)	2	0.17
	Another		3 (100.0)	3	
Heart	Barton	5 (41.7)	7 (58.3)	12	0.24
	Another	1 (16.7)	5 (83.3)	6	
Stroke	Barton	6 (27.3)	16 (72.7)	22	0.93
	Another	1 (25.0)	3 (75.0)	4	
Bronchopneumonia with other conditions	Barton	41 (33.1)	83 (66.9)	124	0.39
	Another	3 (50.0)	3 (50.0)	6	
Bronchopneumonia Only	Barton	23 (65.7)	12 (34.3)	35	-
	Another	-	-	0	
Other conditions	Barton		10 (100.0)	10	-
	Another		3 (100.0)	3	

Table 5.5. Numbers (%) of patients dying from different causes in Redclyffe Annexe, 1995 or later.

Cause of death		opiate		total
		yes	no	
Heart	other		1 (100.0)	1
	Dr Barton		1 (100.0)	1
Stroke	other		4 (100.0)	4
	Dr Barton	1 (100.0)		1
bronchopneumonia plus another	other		17 (100.0)	17
	Dr Barton	1 (100.0)		1
bronchopneumonia only	other			
	Dr Barton	1 (100.0)		1
	Dr Barton	1 (100.0)		1
Other	other		5 (100.0)	5

responsibility for patients in Redclyffe Annexe. One explanation for this finding is that the type of patients being cared for in the Annexe changed at the same time, but an alternative is that the practice of almost routine use of opiates before death was discontinued.

2. Deaths on Dryad ward

Since information was available about admissions to Dryad ward, including some indication of the reason for admission, and whether the patient was discharged alive or had died on the ward, it has been possible to estimate the proportions of patients admitted with different types of illnesses who received opiates, and whether they died. Those patients who received at least one dose of opiate were included in this analysis.

The findings are summarized in Table 5.6. The illness groups are stroke, general medical problems, medical and mental problems, heart problems, cancer, post-operative cases such as fractured neck of femur, and respite care. Thus, of the 17 patients admitted with strokes between March 1995 and August 1998, 10 died, of whom 8 received an opiate. None of those discharged alive had received an opiate. Some patients in all illness groups received an opiate except for those in the respite care group. Of those who were admitted with strokes, 47% received an opiate, the proportion for general medical problems was 71.7%, medical and mental problems 73.2%, heart problems 71.4%, cancer 66.7 %, and post-operative cases 60.9%.

Some qualifications must be made about these data. First, 10 patients had been recorded as receiving an opiate although the admissions book did not record them

as having been admitted. These patients were omitted from the analysis. The most likely explanation is that these patients were on a different ward, the drugs been transferred between wards. Second, no account has been made of the dose, numbers of doses, type of opiate received or administration route. The data will

Table 5.6. Patients on Dryad ward who received an opiate, March 1995 – August 1998, according to illness group and outcome (died or discharged). N=209.

illness group	had an opiate	Outcome		Total
		died	*discharged*	
stroke	No	2 (22.2)	7 (77.8)	9
	yes	8 (100.0)		8
	total	10 (58.8)	7 (41.2)	17
general medical problems	No	7 (26.9)	19 (73.1)	26
	yes	55 (83.3)	11 (16.7)	66
	total	62 (67.4)	30 (32.6)	92
medical/mental problems	No	3 (27.3)	8 (72.7)	11
	yes	29 (96.7)	1 (3.3)	30
	total	32 (78.0)	9 (22.0)	41
heart problems	No		2 (100.0)	2
	yes	5 (100.0)		5
	Total	5 (71.4)	2 (28.6)	7
cancer	No	5 (62.5)	3 (37.5)	8
	yes	16 (100.0)		16
	Total	21(87.5)	3 (12.5)	24
post op	No	3 (33.3)	6 (66.7)	9
	yes	12 (85.7)	2 (14.3)	14
	Total	15	8	23
respite care/ social admission	No		5 (100.0)	5

Total	5 (100.0)	5

therefore include a number of patients who received only one or two doses, although this would be unlikely to change the general conclusion from the table. Third, it is difficult to judge whether individual patients did have a level of pain that justified the use of opiate medication. Without a case by case review, the appropriateness of opiate medication for each patient cannot be determined.

3. Quantities of opiates prescribed per patient

An analysis was undertaken to compare the total amount of opiate prescribed per patient by Dr Barton and other doctors at Gosport. A random sample of patients who had died, and who had been prescribed an opiate, was identified, from those who had died on Dryad, Daedalus or Sultan wards, and for whom complete data from controlled drug registers were available. A total of 46 patients were included, 21 being patients whose deaths had been certified by Dr Barton, and 25 whose deaths had been certified by other doctors. Seventeen patients had died on Dryad ward, nine on Daedalus ward, and 20 on Sultan ward. The amount of opiate prescribed for a patient was calculated by identifying the number of doses, and quantity of drug in each dose, for each drug administered to each patient. Thus, if a patient had been administered subcutaneous diamorphine 20 mgm per day for three days, the total amount would be 60 mgm.

There was no significant difference in the total amount in mgms of diamorphine recorded as administered during the terminal illness, the mean for Dr Barton's patients being 113 mgms (SD 211 mgms) in comparison with 1300 mgms (SD 3354 mgms) for the other doctors (t-test p 0.13). The mean quantity of oramorph for Dr

Barton's patients was 276 mgms (SD 276 mgms) and for the other doctors 169 mgms (SD 168 mgms) (t-test p 0.6). None of Dr Barton's patients in the sample had received morphine sulphate tables, although seven in the comparison group had. One patient of Dr Barton had received fentanyl, and one patient of the other doctors had received methadone.

Some caution is needed in drawing definitive conclusions from this analysis since it did not involve review of the clinical records, and the sample was small. Nevertheless, the findings do not suggest that Dr Barton's patients had received opiates for prolonged periods.

Discussion

The findings of the review of prescribing of controlled drugs indicate that patients in Gosport Hospital whose deaths were certified by Dr Barton were more likely to have been prescribed an opiate (most commonly diamorphine or oramorph). The excess was most evident among patients who were certified as dying from bronchopneumonia with or without other conditions, or from some other condition that was not cancer or cerebro- or cardio-vascular disease. This finding is a cause for concern, since the use of opiates for pain relief in terminal care is more common in conditions in which pain would be expected, in particular cancer. Furthermore, a high proportion of the initial cases referred to the police by concerned relatives had been certified as dying due to bronchopneumonia. It does appear that the practice of almost routine use of opiates before death in Redclyffe Annexe changed when Dr Barton ceased principal responsibility for patients in the Annexe. This may have been a consequence of a change in the practice followed by the doctors who took

over from Dr Barton, or a change in the mix of patients who were admitted to the Annexe.

The finding that the quantities of opiate prescribed, in the analysis of a random sub-sample, did not indicate that Dr Barton had prescribed opiates over prolonged periods is reassuring. However, this finding does not eliminate the possibility that some patients were given opiates unnecessarily. Therefore, the findings of the analyses reported here are consistent with a practice of prescribing opiates to an inappropriately wide group of older patients.

Chapter Six: Analysis of medical certificates of cause of death (MCCDs)

Introduction

This Chapter presents the findings of an analysis of numbers of deaths in general practice certified by Dr Barton. The aim was to determine whether there were greater numbers of deaths than would have been expected, and therefore reasons for concern about the care of patients in general practice. Although most of the review is concerned with deaths in Gosport hospital, it was necessary to be certain that there were no reasons for concern about deaths in the community.

Methods

The data relate to the deaths certified by Dr Barton and a sample of general practitioners chosen because they were caring for similar groups of patients in Gosport at the same time as Dr Barton. There were nine general practices in Gosport, one of which was the practice of Dr Barton and her partners (referred to as the index practice). Levels of deprivation were classified into four levels. In the index practice 6.9% of registered patients were classified in one of the four levels (0.4% in the highest level of deprivation), but in the first control practice 8.4% (2.5% in the highest level) and in the second control practice 7.9% (0.5% in the highest level) were classified in one the deprivation levels. Thus, the comparison practices had a marginally higher proportion of deprived patients. In the index practice, 15.6% of patients were aged 65 years or over; in the first control practice 11.3% and in the second control practice 18.3% of patients were aged 65 years or over. Consequently, the analysis took account of the differences in the age of patients

between practices, but did not account for deprivation since the differences were small.

The MCCDs were identified by National Statistics (see Chapter Two). Deaths from 1993 onwards certified by any of the general practitioners of the three practices were identified using the computer database maintained by National Statistics. Deaths prior to 1993 have not been stored on computer, and therefore a hand search was required of the notifications in the death register of files completed in the registration districts serving the Gosport area (Gosport, Fareham 1, and Havant). The data from these sources had been provided by registrars from the death certificates completed by the general practitioners and additional information provided by the person reporting the death to the registrar (the informant). In this review, information from each death notification was entered into a database for analysis.

The deaths certified by the general practitioners included those that had occurred at home, in nursing homes, or in hospitals, in particular Gosport War Memorial Hospital.

Results

Table 6.1 presents information about the numbers of deaths certified by the sample of GPs who were partners in one of the three practices included in this analysis. The figures for Dr Barton are similar to those identified from certificate counterfoils held at the hospital (see Table 3.2).

Table 6.1. Annual number of deaths, 1987-2002.

year	certifying doctor																					tota
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Dr B	
1987	8	20	7					6	10	11	13			2	15	12	3	9	11		17	2	14
1988	4	8	4					10	12	10	11				5	8	5	5	6	1	15	28	13
1989	4	11	10					20	9	13	14				6	9	8	8	5	2	9	39	16
1990	20	11	7	5				8	17	13	17				10	13	1	4	4			41	17
1991	16	20	13	9				7	5	12	11				11	10	7	5				37	16
1992	5	10	8	18				9	10	8	13				9	10	3	5				36	14
1993	8	10	13	7	3			8	9	7	11	1			5							97	17
1994	4	8	5	9	4			12	4	5	12				9							106	17
1995	7	12	8	9	2			8	10	18	9	13	9		6							81	19
1996	15	9	11	11	7			10	5	9	5	11	9									86	18
1997	7	6	3	10	5	1		19	13	5	9	6	8									92	18
1998	5	9	7	10	5	8		2	13	9	15	12	14									108	21
1999	7	9	4	10	4	12	8	2	9	13	9	1	7									94	18
2000	3	5	5	7	5	11	4		7	6	13	7										35	10
2001	7	17	9	1	1	13	2	1	5	4	6	8	1									5	8
2002	9	8	4	9	5	8	5	7	5	5	5	10											8
	129	173	118	115	41	53	19	129	143	148	173	69	48	2	76	62	27	36	26	3	41	887	251

Deaths in Gosport hospital

Dr Barton's partners provided cover at Gosport hospital during her absences (due to vacations and other reasons). Figures 3.1 to 3.15 reveal periods of one or more weeks in which Dr Barton did not issue a certificate for a patient who had died in Gosport hospital, and one explanation for these weeks is that she was on vacation. A comparison of death certification rates by her partners, relating to patients on Daedalus and Dryad wards during those periods of absence, with certification rates by Dr Barton on the same wards when she was present would be of particular interest. A high death rate when Dr Barton was present and a lower rate when she was on leave would raise questions about the impact of her clinical practice on mortality rates.

However, some difficulties of interpretation might remain since mortality during her absences could in part reflect effects of her practice when present, possibly leading to attenuation of observable differences. Also, the delay of the admission of

seriously ill patients until Dr Barton's return may serve as an explanation for differences in deaths rates between normal and holiday periods. Unfortunately, it has proved impossible to obtain information about the doctors' rota for Daedalus and Dryad wards and the analysis reported below differs from a straightforward comparison in two respects:

a) Since individual wards cannot be consistently identified from the place of death details on the certificates, the analysis relates to deaths from all wards at Gosport certified by Dr Barton or her partners. These include deaths of patients in Sultan ward who would have been under the care of their general practitioner as well as deaths in Dryad and Daedalus wards, under the care of the Department of Medicine for Elderly People.

b) Since records of Dr Barton's rota are no longer available, an indirect method of inferring (some of) these periods of absence has been used, as described below, but the validity of this method cannot be verified directly.

Absence of Dr Barton has been inferred from prolonged periods between consecutive deaths certified by her. Such periods could of course occur by chance even when Dr Barton is present. A variety of period lengths has been investigated. The principal results below are based on periods of at least 14 consecutive days, since use of shorter periods are more prone to error, such as uncertainty over the exact start and end dates.

Rates of certification by Dr Barton, except during those periods in which there was at least 14 days between successive certifications by her, were compared with rates of certification by the seven other practice partners in those same 14+ day periods. Incidence ratios (and 95% confidence intervals) were: 1.67 (0.88-3.59) in 1998, 3.78 (1.91-8.52) in 1999, and 1.25 (0.49-4.11) in 2000. If the three 1998-2000 years were considered together, the incidence ratio was 2.24 (1.47-3.55).

In interpreting these ratios, it is helpful to consider the magnitude and direction of possible biases. End-estimate bias in the 14-day intervals is unlikely to exceed 15% (two end days in 14 days); they could operate in either direction (that is increasing or decreasing the true estimate). If Dr Barton had been absent for periods shorter than 14 days, this will lead to under estimation of her rates. If the 14+ day periods are chance occurrences not corresponding to her absence, her rates will be overestimated, by up to 30%. If, as noted earlier, Dr Barton's practice while present impacted on her partners' certification rates during her absence, the incidence ratio might be reduced.

Taking these factors into account, it is difficult to draw secure conclusions. The incidence ratio in 1999 was markedly raised, and this finding may point to a method for exploring further any potential impact of Dr Barton's clinical practice on mortality rates. It has not been possible to obtain reliable information about holiday periods in this review, but this may be possible in the continuing police investigation, in which case the pilot analysis included here should be repeated using valid holiday data.

Deaths at home or in nursing or residential homes

Table 6.2 presents information relating to deaths at home, or in residential or nursing homes, certified by the same group of GPs. Since Dr Barton was required to care for patients in Gosport War Memorial Hospital, she may be expected to have undertaken a reduced workload in the general practice. The findings indicate that Dr Barton issued fewer certificates than most of the other GPs, although some (probably part-timers, or doctors leaving general practice between 1993-5) issued fewer. This finding is reassuring, since it reduces concern about care given to patients in the community. It is notable that Dr Barton issued no certificates in 2002.

Table 6.2. Annual number of deaths at home or in residential/nursing homes certified by GPs, 1987-2002.

year	certifying doctor																					total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Dr B	
1987	4	13	7					4	6	7	10			2	10	9	3	5	4		10	2	96
1988	1	6	2					9	10	6	8				3	5	4	5	6	1	10	9	85
1989	3	7	7					20	6	5	11				5	6	8	6	3	2	9	9	107
1990	12	6	5	3				7	15	9	11				7	7	1	4	3			3	93
1991	15	15	10	7				7	4	9	9				10	5	7	4				5	107
1992	2	6	6	10				7	8	5	11				6	6	2	4				4	77
1993	5	7	10	5	1			6	7	5	8	1			5							3	63
1994	1	5	4	7	4			9	3	3	10				5							2	53
1995	4	9	6	7	2			8	6	8	7	10	2		3							1	73
1996	10	5	6	8	5			7	3	3	4	6	1									2	60
1997	5	1	1	10	1			15	9	2	6	3	3									6	62
1998	5	7	6	9	1	6		1	8	4	6	9	4									1	67
1999	6	6	3	7	4	10	7		5	4	6	1	5									2	66
2000	2	3	4	4	4	11	2		5	5	7	6										1	54
2001	6	13	8	1	1	11	2	1	2	3	5	7	1									3	64
2002	9	7	3	7	1	7	5	3	4	4	4	7											61
	90	116	88	85	24	45	16	104	101	82	123	50	16	2	54	38	25	28	16	3	29	53	1188

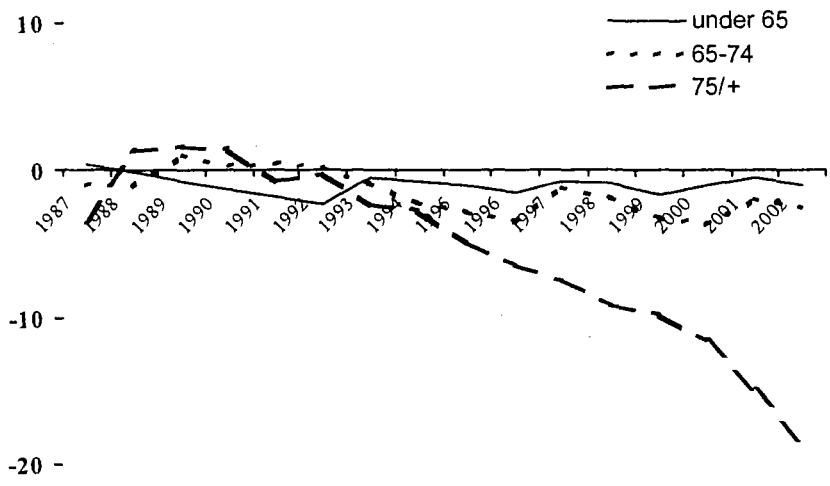
Although Table 6.2 provides some reassurance, a more detailed analysis is required that takes into account the numbers of patients registered with the included general practices. This additional information would enable calculation of the rate of deaths in the three practices, and provide a more meaningful comparison between Dr Barton and other doctors. Information about the numbers of patients registered with each general practitioner was obtained from the Hampshire and Isle of Wight Practitioners and Patient Services. Although the Agency was able to supply information from 1987 onwards about the numbers of patients in three age bands (0-64 years, 65-74 year, and 75 years and over), details on the numbers who were male and female were available only from 1996.

The number of patients registered with a general practitioner is not necessarily an accurate reflection of the number of patients the doctor directly cares for. Within a general practice, some doctors may undertake work outside the practice (as did Dr Barton) and therefore not care for so many patients in the practice. A doctor may

choose to work part-time for other reasons. Therefore, the numbers of patients registered with the doctor were not used in estimating mortality rates. Since detailed information about the work patterns of the general practitioners in the comparison practices was not available, the numbers of patients cared for by each general practitioner was taken to be an equal share of the total practice list size. For example, using this method, in a practice of five doctors and with a total of 10,000 registered patients, the numbers cared for by a single doctor would be assumed to be 2000.

Deaths among males and females combined up to 1995 are shown in Table 6.3 to 6.5, and deaths among males and females separately from 1996 to 2002 are shown in Tables 6.6 to 6.10. Each Table displays the numbers of deaths certified by doctors in the comparison practice, the numbers certified in Dr Barton's practice (the index practice), and the numbers certified by Dr Barton. The Tables also show the numbers of patients registered with the comparison and index practices, and the estimated number under the care of Dr Barton. These data are used to calculate the number of certificates that would have been expected to have been certified by Dr Barton based on the comparison practices, and the difference between the expected number and the number she did in fact certify. In all but two of the Tables, the total of the difference between the numbers expected and observed is less than zero. The cumulative difference between the expected and observed numbers of deaths in the three age bands is displayed in Figure 6.1.

Figure 6.1. The cumulative difference between the observed and expected numbers of MCCDs issued by Dr Barton, 1987-2002. (Deaths occurring at home, or in residential or nursing homes).



By 2002, the total difference between the observed and expected certificates issued by Dr Barton was –0.99 for patients aged 0-64, -2.54 for those aged 65 to 74, and -18.53 for those aged 75 and over. These figures provide further reassurance about the care given to patients in general practice.

Table 6.3. Deaths and death rates/1000 patients under the age of 65 1987-1995 (males and females).

year	Patients in control practices	Deaths in control practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected deaths	Observed – expected, Dr Barton
1987	15376	5	8644	10	.33	1.16	1729	1	.57	.43
1988	15457	5	8569	7	.32	.82	1714	0	.55	-.55
1989	15673	5	8665	3	.32	.35	1733	0	.55	-.55
1990	15490	5	8634	7	.32	.81	1727	0	.55	-.55
1991	13192	4	8644	5	.30	.58	1729	0	.52	-.52
1992	13009	4	8578	2	.31	.23	1716	0	.53	-.53
1993	12933	2	8535	4	.15	.47	1707	2	.26	1.74
1994	13055	1	10819	2	.08	.18	1803	0	.14	-.14
1995	13244	2	10745	4	.15	.37	1791	0	.27	-.27
Total observed - expected										-.94

Table 6.4. Deaths and death rates/1000 patients age 65 - 74 1987-1995 (males and females).

year	Patients in control practices	Deaths in control practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1987	1271	8	783	6	6.29	7.66	157	0	.98	-.98
1988	1315	8	788	9	6.08	11.42	158	1	.96	0.04
1989	1326	8	788	8	6.03	10.15	158	3	.95	2.05
1990	1331	7	785	7	5.25	8.92	157	0	.82	-.82
1991	1176	14	800	6	11.90	7.50	160	2	1.90	0.10
1992	1144	9	805	6	7.87	7.45	161	1	1.27	-.27
1993	1145	7	779	6	6.11	7.70	156	0	.95	-.95
1994	1157	9	986	2	7.78	2.03	164	0	1.28	-1.28
1995	1147	5	993	8	4.36	8.06	166	0	.72	-.72
Total observed - expected										-2.83

Table 6.5. Deaths and death rates/1000 patients age 75 and above 1987 – 1995 (males and females).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1987	1231	38	688	28	30.86	40.70	138	1	4.26	-3.26
1988	1231	31	687	25	25.18	36.39	137	8	3.45	4.55
1989	1234	52	677	31	42.14	45.79	135	6	5.69	0.31
1990	1227	29	667	38	23.63	56.97	133	3	3.14	-.14
1991	1138	46	640	31	40.42	48.44	128	3	5.17	-2.17
1992	1125	23	616	32	20.44	51.95	123	3	2.51	.49
1993	1087	27	622	19	24.84	30.55	124	1	3.08	-2.08
1994	1091	20	753	19	18.33	25.23	126	2	2.31	-.31
1995	1120	28	771	25	25.00	32.43	129	1	3.23	-2.23
Total observed - expected										-4.84

Table 6.6. Deaths and death rates/1000 patients age below 65 1996-2002 (females).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	6978	2	5307	0	.29	0	885	0	.26	-.26
1997	6983	0	5259	2	0	.38	877	0	0	0
1998	7078	1	5094	3	.14	.59	849	0	.12	-.12
1999	7233	2	4981	0	.28	0	830	0	.23	-.23
2000	7311	1	4964	2	.14	.40	827	1	.12	.88
2001	7379	3	4903	1	.41	.20	817	0	.33	-.33
2002	7407	2	4935	2	.27	.41	823	0	.22	-.22
Total observed - expected										-.28

Table 6.7. Deaths and death rates/1000 patients age below 65, 1996 - 2002 (males).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	6426	2	5244	1	.31	.19	874	0	.27	-.27
1997	6475	2	5238	2	.31	.38	873	1	.27	.73
1998	6509	0	5127	1	0	.20	855	0	0	0
1999	6665	4	5058	2	.60	.40	843	0	.51	-.51
2000	6839	2	5048	3	.29	.59	841	0	0.24	-.24
2001	7040	1	5005	2	.14	.40	834	1	.12	0.88
2002	7011	3	5003	0	.43	0	834	0	.36	-.36
Total observed - expected										0.23

Table 6.8. Deaths and death rates/1000 patients age 65 to 74, 1996-2002 (females).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	626	0	521	1	0	1.92	87	0	0	0
1997	620	2	508	0	3.23	0	85	0	.27	-.27
1998	618	3	498	0	4.85	0	83	0	.40	-.40
1999	634	3	508	1	4.73	1.97	85	0	.40	-.40
2000	668	1	533	3	1.50	5.63	89	0	.13	-.13
2001	685	0	535	2	0	3.74	89	2	0	2
2002	699	3	543	0	4.29	0	91	0	.39	-.39
Total observed - expected										.41

Table 6.9. Deaths and death rates/1000 patients age 65 – 74, 1996-2002 (males).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	529	4	461	4	7.56	8.68	77	0	.58	-.58
1997	526	3	472	5	5.70	10.59	79	3	.45	2.55
1998	543	3	457	2	5.52	4.38	76	0	.42	-.42
1999	538	6	450	0	11.15	0	75	0	.84	-.84
2000	552	3	469	2	5.43	4.26	78	0	.42	-.42
2001	577	1	474	0	1.73	0	79	0	.14	-.14
2002	593	2	478	2	3.37	4.18	80	0	.27	-.27
Total observed - expected										-.12

Table 6.10. Deaths and death rates/1000 patients age 75 and above, 1996-2002 (females).

year	Patients in control practices	Deaths in index practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	752	25	471	9	33.24	19.11	79	2	2.63	-.63
1997	731	17	494	15	23.26	30.36	82	2	1.91	.09
1998	730	15	511	13	20.55	25.44	85	0	1.75	-1.75
1999	742	14	491	11	18.87	22.40	82	2	1.55	.45
2000	736	9	492	8	12.23	16.26	82	0	1.00	-1.00
2001	779	22	505	9	28.24	17.82	84	0	2.37	-2.37
2002	770	24	508	7	31.17	13.78	85	0	2.65	-2.65
Total observed - expected										-7.86

Table 6.11. Deaths and death rates/1000 patients age 75 and above, 1996 - 2002 (males).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	371	8	279	3	21.56	10.75	47	0	1.01	-1.01
1997	389	9	273	4	23.14	14.65	46	0	1.06	-1.06
1998	387	7	283	14	18.09	49.47	47	1	.85	.15
1999	408	9	281	8	22.06	28.47	47	0	1.04	-1.04
2000	415	8	280	10	19.28	35.71	47	0	.91	-.91
2001	448	9	293	5	20.09	17.06	49	0	.98	-.98
2002	461	8	308	8	17.35	25.97	51	0	.88	-.88
Total observed - expected										-5.88

Table 6.12. Numbers (%) of patients certified by Dr Barton or other general practitioners dying at home or in residential or nursing homes.

place of death	doctor		total
	Dr Barton	other GPs	
own home	28 (52.8)	533 (47.0)	561 (47.2)
residential or nursing home	25 (47.2)	602 (53.0)	627 (52.8)
	53	1135	1188

There was no significant difference in the proportion of patients who died at home or in residential or nursing homes between Dr Barton and the other general practitioners (Table 6.12). Of the 53 patients of Dr Barton who died at home or in residential or nursing homes, 41 (77.4%) were females in comparison with 648 (57.1%) of the 1135 certified by the other general practitioners (Chi Sq 8.5, $p<0.003$).

Table 6.13. Numbers (%) of patients certified as dying from different conditions (Chi 17.6, df 5, p <0.004).

cause of death	doctor		total
	Dr Barton	other GPs	
cancer	7 (13.2)	248 (21.9)	255 (21.5)
heart	23 (43.4)	336 (29.6)	359 (30.2)
stroke	2 (3.8)	115 (10.1)	117 (9.8)
bronchopneumonia plus	15 (28.3)	219 (19.3)	234 (19.7)
bronchopneumonia alone	5 (9.4)	51 (4.5)	56 (4.7)
other	1 (1.9)	166 (14.6)	167 (14.1)
	53	1135	1188
	53	1135	1188

The mean age of the patients whose deaths were certified by Dr Barton was 76.4 years, and among the patients of the other general practitioners the mean age was 79.6 (not significantly different). Dr Barton certified a greater proportion of cases as due to heart conditions (Table 6.13), although it should be noted that the numbers of cases involved were small.

Discussion

The analyses reported in this Chapter were based on death notifications identified by National Statistics. The number of deaths certified by Dr Barton in Gosport hospital as indicated by these notifications was similar to that identified by the counterfoils of books of MCCDs, and it is reasonable to conclude that information about almost all deaths has been identified.

The findings indicate that the numbers of deaths certified by Dr Barton for patients who died at home or in residential or nursing homes was less than would have been expected if she had cared for the same number of patients as her partners. Since she undertook sessions in Gosport hospital, it is unlikely that she did in fact care for the same numbers of patients as her partners, but the proportion is difficult to estimate without the provision of information from the practice. Since a police investigation is underway, direct contact with the practice was judged to be inappropriate. Therefore, it has been assumed that each partner in the practice was responsible for more or less the same number of patients.

The analysis indicated that the numbers of deaths certified by Dr Barton was less than would have been expected in comparison with the other general practitioners. If Dr Barton had cared for fewer patients than her colleagues, a lower number of certificates would have been expected, and the finding almost certainly reflects the

fact the Dr Barton was indeed responsible for fewer patients than the other general practitioners. Nevertheless, the finding does provide reassurance about care of patients in general practice.

In an additional analysis, an estimate of any effect of holidays and other absences on mortality rates in Daedalus and Dryad wards was attempted. However, the assumptions required in this analysis make the findings of little direct value. Since no information about actual vacations and other periods of absence was available, it is impossible to be confident that the periods in which no certificates were issued occurred because Dr Barton was absent, or whether there were in fact, no deaths to be certified in those weeks. However, if more information about periods of absence can be obtained in the police investigation, this analysis should be repeated.

Chapter Seven: Conclusions

In this audit or review, information has been obtained from a variety of sources about the care delivered to patients of the Department of Medicine for Elderly People at Gosport War Memorial Hospital, including death notifications stored by National Statistics, the counterfoils of medical certificates of cause of death, clinical records, controlled drug registers, and ward admissions books. Whilst there are inevitable reservations about the completeness of these sources, when viewed together they enable conclusions to be reached. In this Chapter, the reservations about the data used in the review are summarised, the findings are outlined, and conclusions are presented. Relevant recommendations are also made.

The sources of information

It has not been possible to undertake a comparison of mortality rates between Gosport and other community hospitals because centrally held Hospital Episode Statistics data do have sufficiently detailed provider codes to identify groups of patients similar to those admitted to Gosport. However, whilst such an analysis would be desirable, I would not expect that the findings would significantly alter the conclusions of this review.

The notifications of deaths provided by National Statistics were a reliable source of information about the numbers of deaths certified by Dr Barton and the comparison general practitioners. Therefore, conclusions based on this information can be regarded as safe. It should be noted, however, that notifications would not have included information about cases certified by coroners. The data provided by National Statistics corroborate the numbers of deaths identified from the counterfoils of MCCDS that had been stored at Gosport hospital. Consequently, the findings from

the analysis of the counterfoils can also be regarded as reliable, although the lack of information about cases investigated by the coroner must be noted again.

The data contained in the controlled drugs registers are likely to have been reasonably accurate and complete, although it is not possible to verify this through comparison with another source. The administration of controlled drug registers must be recorded in registers, and the registers at Gosport did appear to have been maintained correctly. Ward admission books are not required to be maintained to such a standard, and the policy on admission books varied in different wards. Only Dryad ward's book was found to be a satisfactory source of information. The admission books are therefore the source of information about which there should be most caution. Nevertheless, significant weaknesses in the information in the books were not detected during the review, and they probably do represent a reasonable record of the admissions of patients to the ward.

Summary of findings

The investigation of a random sample of records indicated that:

- Patients admitted to Gosport hospital were elderly, had severe clinical problems, and had commonly been transferred from acute hospitals after prolonged in-patient stays. Although some were admitted for rehabilitation, most were believed to be unlikely to improve sufficiently to permit discharge to a nursing home.
- Of the 81 patients in the sample, 76 (94%) had received an opiate before death, of whom 72 (89%) had received diamorphine.
- When administered by syringe driver, diamorphine was invariably accompanied by other medication, most commonly hyoscine and midazolam.

- The mean starting dose of diamorphine was greater than would have been expected if the rule of thumb of giving one third of the total daily dose of morphine had been followed.
- Opiates were used for patients with all types of conditions, including strokes, heart conditions, and end stage dementia.
- There was little evidence of the three analgesia steps recommended in palliative care (non-opiate, then weak opiate, then strong opiate).
- Opiates were commonly prescribed on admission, although not administered until some days or even weeks later.
- Some records failed to indicate that an acute deterioration in a patient's condition had been followed by a careful assessment to determine the cause. Opiates may have been administered prematurely in such cases.
- The records commonly did not report detailed assessments of the cause of the patient's pain.
- The pattern of early use of opiate medication was evident from 1988.
- The records did not contain full details of care. Only 48 (59.3%) contained sufficient information to enable a judgement to be made about the appropriateness of care. In 16 of these, I had some concerns about the indications for starting opiates, the investigation of pain, or in the choice of analgesic.
- Dr Barton did not report recent fractures, including fractured hips, on MCCDs. These cases were commonly reported as having died from bronchopneumonia.

The counterfoils of MCCDs stored at Gosport hospital indicated that:

- Dr Barton had issued 854 certificates from 1987.

- The number of certificates was between 30 and 40 per year between 1988 and 1992, when Dr Barton was responsible for patients in Redclyffe Annexe and some in the male and female wards. The numbers increased to between 80 and 107 per year between 1993 and 1999 when Dr Barton became responsible for patients in Daedalus and Dryad wards.
- Dr Barton issued between nil and six MCCDs per week. There were no clear clusters of deaths.
- Dr Barton was more likely than other doctors to give bronchopneumonia with other conditions or bronchopneumonia only as the cause of death.

The investigation of Dryad ward's admissions books indicated that:

- Of the 684 patients admitted between 1993 and 2001, 405 (59.2%) died in the ward.
- The mean age of the people admitted was 82.7, and around three quarters had been transferred from an acute hospital.
- There was a change in the patients admitted to the ward from around 1997. After that year, there was an increase in the proportion of patients who had been admitted for respite care, and by 1999, the proportion of patients who died had decreased.
- The proportions of patients who died in each hour of the day were as would normally be expected.

The investigation of controlled drugs registers indicated that:

- Patients in whom the MCCDs had been issued by Dr Barton were more likely to have received an opiate before death.

- The greater use of opiates was found in relation to all causes of death except cancer, although when this analysis was confined to patients in Redclyffe Annexe, there were no significant differences between Dr Barton and other doctors.
- Dr Barton did not prescribe opiates to individual patients for longer periods of time than other doctors.

The investigation of MCCDs indicated that:

- The counterfoils stored at Gosport hospital were an accurate record of the deaths in the hospital.
- There was no evidence that more than the expected number of deaths had been certified by Dr Barton. In fact, the number was less than expected if Dr Barton had undertaken an equal share of the workload in general practice.
- A greater proportion of MCCDs issued by Dr Barton were for female patients, and were more likely to have been certified as dying from heart conditions. These findings are probably incidental and are not reason for concern.

Conclusions

Patients admitted to Gosport were elderly and with severe clinical problems. Most had been transferred from acute hospital settings after a period of intensive management, at the end of which it had been concluded that further intensive management would have little or no benefit. Patients were transferred to Gosport either for rehabilitation or for continuing care (defined by CHI as 'a long period of treatment for patients whose recovery will be limited').

In this group of very ill and dependent patients, a practice of liberal use of opiate medication can be discerned from the findings of the review. Patients who

experienced pain, and in whom death was judged to be a likely outcome in the short term, were given opiates. Alternative management with other analgesics or detailed assessment of the cause of pain or distress was generally ruled out. This practice may be described as the almost routine use of opiates before death. The practice was followed irrespective of the principal clinical condition. Patients whose main problems were dementia, strokes, bronchopneumonia or neurological problems all received opiates. A potential explanation is that care was as in advance of care elsewhere in the NHS at the time. General concerns have been raised about the end stage care of people with dementia and other problems, in particular the finding that many such patients have not received adequate analgesia, although they have received antibiotics or other treatments intended to be curative.

However, the proportion of patients at Gosport who did receive opiates before death is remarkably high, and it is difficult to accept that the practice of almost routine use of opiates before death, dating from 1988 or earlier, merely represents clinical practice in advance of practice elsewhere. The practice may be summed up in the words found in many clinical records – 'please make comfortable'. This phrase also points to a prevailing attitude or culture of limited hope and expectations towards the potential recovery of patients in Gosport. But in some patients, a different attitude that might be phrased 'determined rehabilitation' could well have led to a different outcome.

The review of records has raised concerns about the degree of assessment of patients whose condition deteriorated, and the level of consideration given to decisions to commence opiates. Consequently, it is difficult not to conclude that some patients were given opiates should have received other treatment. Only a detailed investigation of individual cases, in which the accounts of witnesses as well

as documentary evidence are considered, can conclude whether lives were shortened by the almost routine use of opiates before death, but I would expect such case by case investigations to conclude that in some cases, the early resort to opiates will be found to have shortened life. I would also expect that in a smaller number of cases, the practice will be found to have shortened the lives of people who would have had a good chance of surviving to be discharged from hospital.

From the evidence considered in this review, it is not possible to determine how the practice of almost routine use of opiates at Gosport originated. Whilst much of the review has focused on the work of Dr Barton, this is because she issued the MCCDs and made most of the entries in the clinical records. However, this should not be taken as meaning that she was the origin of the practice, she may merely have been implementing it. Indeed, the practice may have been introduced before Dr Barton began work in Gosport as a clinical assistant in 1988.

Recommendations

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.

4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to suspect that some patients at the end of life do not receive adequate analgesia.
5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

CPT FILE
(Lon)

CPT DOCUMENTS BEGIN

RCB

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Tel: 0845 0454545

Fax: 01962 871204

Telex: 47361 HANPOL

Paul R. Kernaghan
QPM LL.B MA DPM MCIPD
Chief Constable

Your ref:

Our ref: CC/LR/smg

22 December 2004

Finlay Scott TD
Chief Executive and Registrar
General Medical Council
2nd Floor
Regents Place
350 Euston Road
London
NW1 3JN

cc cc
cc

Dear Mr Scott

Operation Rochester

I am writing on behalf of the Chief Constable to acknowledge receipt of your letter dated 6 December 2004, received at this office on 13 December 2004.

Mr Kernaghan has caused enquiries to be made and a reply will be provided as soon as reasonably practicable.

Yours sincerely

Code A

L Rickwood [Inspector]
Staff Officer to Paul Kernaghan
Chief Constable

Fareham and Gosport

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

Tel: 01329 233447
Fax: 01329 234984

Mr Paul Hylton
Assistant Registrar
General Medical Council
2nd Floor
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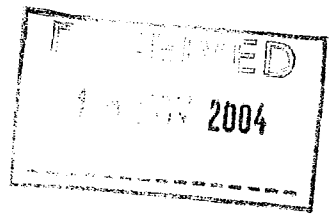

12 November 2004

Dear Mr Hylton

RE: DR JANE BARTON

Firstly, I apologise in the delay in writing a response to you on the issues and questions contained in your letter of 8th October 2004.

I am replying on behalf of Mr Piper as Deputy Chief Executive, I take the lead on all aspects of the Gosport War Memorial Inquiry – in conjunction with the Chair of the Professional Executive Committee (Dr Gordon Sommerville) and the Chair of the PCT Board, (Lucy Docherty).

Dr Barton, as an independent contractor, agreed to a voluntary arrangement from 1st October 2002 that she would not prescribe benzodiazepines or opiate analgesics. All patients requiring such drugs as part of ongoing therapy would be transferred to other partners in the practice. This way care would not be compromised. She also agreed not to accept house visits if there was a possible need for such drugs to be prescribed, and to review previous prescriptions for high quantities of these drugs.

The voluntary agreement is still in place.

Data on drugs prescribed has been obtained from both PPA and the practice system and reviewed by the PCT periodically since the start of this agreement. Copies of the detail have been shared with her.

There are reports of this data within the PCT. I will arrange for the PCT Pharmaceutical Advisor (Hazel Bagshaw) to send you copies of such reports.

Yours sincerely

Code A

Alan Pickering
Deputy Chief Executive

Michael
Foster carried
-Met 7/4
- will

SENDING CONFIRMATION

DATE : 6-OCT-2004 WED 16:34
NAME : FPD
TEL : Code A

PHONE	:	Code A
PAGES	:	12/12
START TIME	:	6-OCT 16:29
ELAPSED TIME	:	04' 38"
MODE	:	ECM
RESULTS	:	OK

FIRST PAGE OF RECENT DOCUMENT TRANSMITTED...

Urgent - Confidential

To Mr Roger Henderson QC
Fax number Code A
From Paul Hylton
Direct Dial Code A
Direct fax
No. of pages (inclusive) *Time* *Date* 6 October 2004

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr. Henderson

Dr Jane Barton

Please find attached a copy of the expert summary in respect of Catherine Lee.

I have also managed to trace a copy of the June 2001 transcript at our external solicitors.

SENDING CONFIRMATION

DATE : 6-OCT-2004 WED 14:50
NAME : FPD
TEL : Code A

PHONE : Code A
PAGES : 4/4
START TIME : 6-OCT 14:49
ELAPSED TIME : 01'05"
MODE : ECM
RESULTS : OK

FIRST PAGE OF RECENT DOCUMENT TRANSMITTED...

Urgent - Confidential

To Ian Barker - MDU
Fax number
From Paul Hylton
Direct Dial Code A
Direct fax
No. of pages (inclusive) 4 *Time* *Date* 6 October 2004

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Ian

Dr Jane Barton

We have just noticed that the attached expert summary in respect of Catherine Lee was inadvertently omitted from the bundle to be considered tomorrow.

I will ensure that it is added as a supplement to the bundle.

SENDING CONFIRMATION

DATE : 6-OCT-2004 WED 14:09
NAME : FPD
TEL : Code A

280 – 289
bundle 21/3/Hearing

PHONE	:	Code A
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RESULTS	:	OK

FIRST PAGE OF RECENT DOCUMENT TRANSMITTED...

Urgent - Confidential

To Ian Barker - MDU
Fax number Code A
From Paul Hylton
Direct Dial Code A
Direct fax

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

No. of pages (inclusive) *Time* *Date* 6 October 2004

Dear Ian

Dr Jane Barton – IOC Hearing 7 October 2004

Our Counsel has asked that the attached Citations be available to the Committee for tomorrow's hearing.

We thought it courteous to provide you with copies of the Citations prior to the hearing.

MILLS & REEVE

		Fax Number	Reference
To:	Paul Hylton General Medical Council	Code A	
From:	Kevin Duce Senior Solicitor Code A	Code A	BKMD/4002044-0131-0
Date:	6 October 2004		
Pages:	11	Document number: 80516951_1.doc	

Jane Barton

Paul

IOC transcript 21 June 2001.

Regards

Code A

Kevin

Mills & Reeve
54 Hagley Road
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Birmingham
B16 8PE

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Fax: +44(0)121 456 3631
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info@mills-reeve.com

IOC REFERRALS

DOCTORS' FULL NAME :	Dr Jane Ann BARTON
FPD REFERENCE :	2000/2047
TYPE OF CASE : (Performance/Health/Conduct)	Conduct
CASE WORKER :	Paul Hylton
DOCTORS' PLACE OF PRACTICE :	Hampshire
DOCTORS' SPECIALTY :	Clinical Assistant in elderly medicine
DATE INFORMATION RECEIVED :	Case previously considered by the IOC in 2002. Further info received from Hampshire Police on 10 September 2004.
DATE OF REFERRAL TO IOC :	24 September 2004
REFERRED BY :	The President
MEMBER/ASSOCIATES(S) THAT HAVE SEEN CASE:	Committees at previous IOC hearings. PPC hearing 29 – 30 August 2002 (Professor Roger Green, Dr Richard Kennedy, Sir Roddy MacSween, Dr Sheila Mann and Professor Nigel Stott
IS DOCTORS CURRENTLY PRACTISING:	Yes.

SUMMARY OF ALLEGATIONS:

Some of the Information in this case has previously been considered by the IOC in 2001 and 2002. The information was referred to the GMC by Hampshire Constabulary as a result of enquiries by them into the deaths of a number of patients at Gosport War Memorial Hospital. This latest referral to the IOC was made by the President.

The Police have now progressed their enquiries to the point that they have been able to disclose information in respect of 19 patients whose treatment their experts believe, having carried out a preliminary screening exercise, may have been sub-standard. The Police have disclosed the medical records, Police reports and expert screening forms for those 19 patients, and it appeared to the

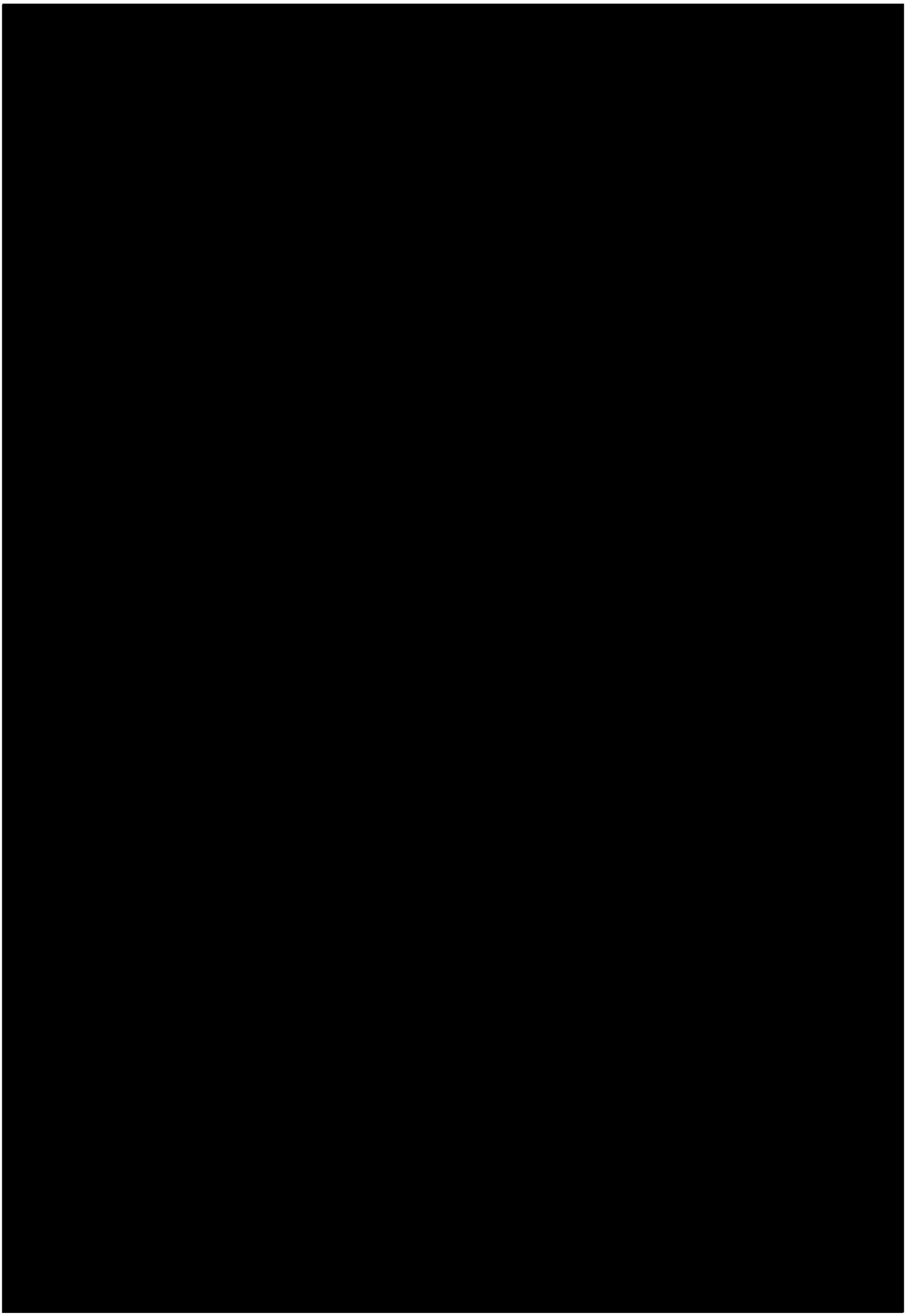
President that in 14 cases there may be information that should be put before the IOC.

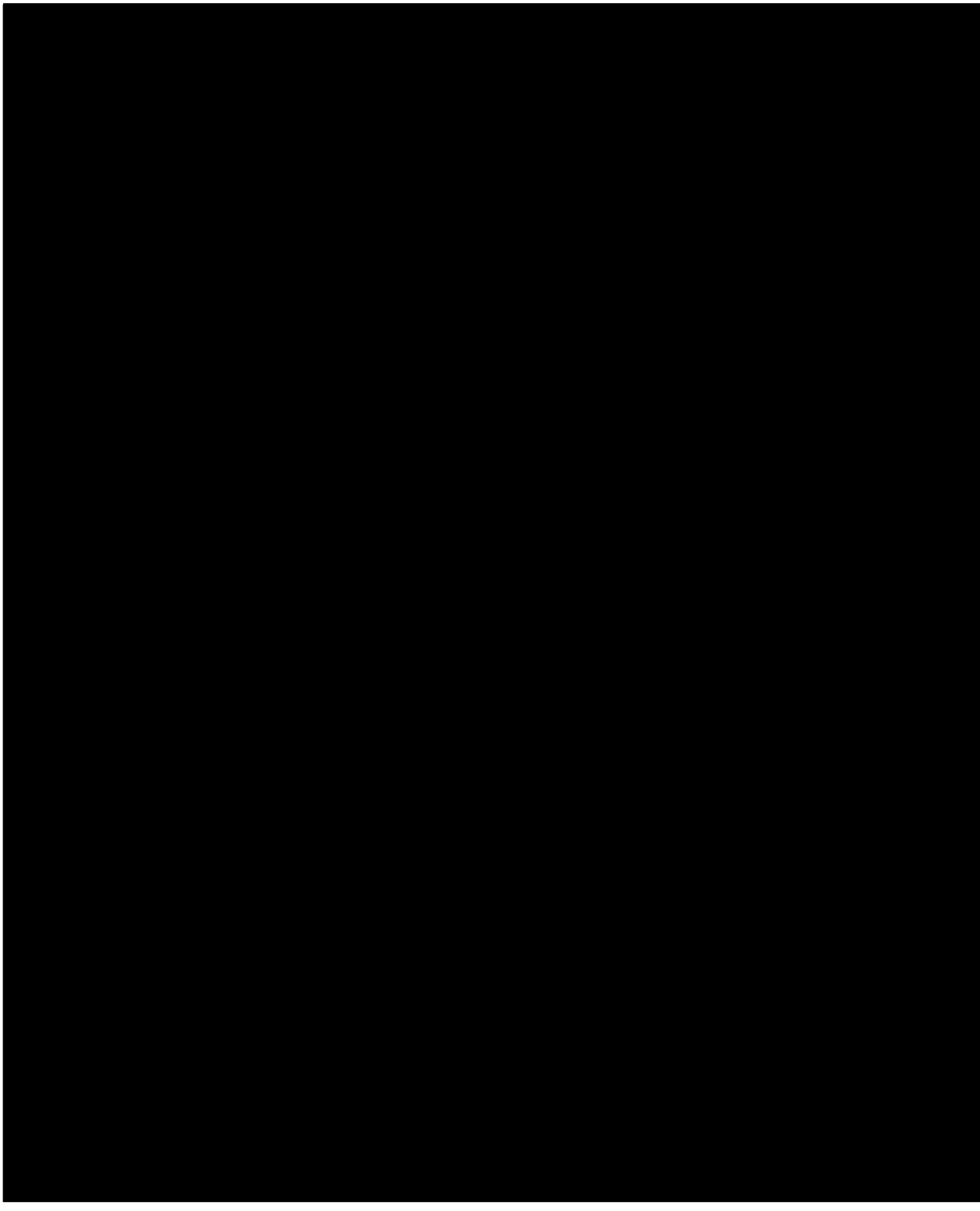
The Police have referred information in respect of 10 – 15 other patients whose treatment their experts believe, having carried out a preliminary screening exercise, was such that criminal charges against Dr Barton should be considered. The Police have been asked to prepare a statement disclosing as much information as is possible at this stage of the investigation in respect of these more serious cases, and we should receive this by 28 September 2004.

Dr Barton has been informed of the referral and has been told that we will disclose to her all of the information that we will put before the Committee by 30 September 2004.

To be Completed by IOC Secretariat

Date referral form received	Date of IOC Hearing	Date caseworker notified of IOC hearing date





Paul Hylton Code A

From: Graeme Catto Code A
Sent: 24 Sep 2004 14:00
To: 'Paul Philip Code A
Cc: 'Finlay Scott Code A ; 'Paul Hylton Code A
Subject: RE: Dr Jane Barton

Paul

Thanks – I am content that Dr Barton be referred to the IOC as you suggest.

Graeme

Sir Graeme Catto

President
General Medical Council
178 Great Portland Street
London, W1W 5JE

Tel; Code A
Fax:
email:

From: Paul Philip Code A
Sent: 24 September 2004 13:05
To: Professor Sir Graeme Catto
Cc: Finlay Scott Code A); Paul Hylton Code A
Subject: Dr Jane Barton

Graeme,

I would be grateful if you would consider referring this doctor to the IOC.

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Roger Henderson will present the case at the IOC on 6th October, if you agree. Let me know if you would like any further information.

Regards

Paul

General Medical Council
178 Great Portland Street London W1W 5JE
Tel: +44 (0) 20 7580 7642
Fax: +44 (0) 20 7915 3641

Paul Hylton Code A

From: Adam Elliott Code A
Sent: 24 Sep 2004 12:12
To: Paul Hylton (Code A
Subject: RE: Dr Jane Barton

Paul,

The date is 7 October 2004 and location is General Chiropractic Council
44 Wicklow Street
LONDON
WC1X 9HL
United Kingdom

Start time 09:30

Adam

-----Original Message-----
From: Paul Hylton (Code A
Sent: 24 Sep 2004 12:08
To: Adam Elliott Code A
Subject: FW: Dr Jane Barton
Importance: High

Adam

Is the date right?

Paul

-----Original Message-----
From: Paul Philip (Code A
Sent: 24 Sep 2004 12:05
To: Professor Sir Graeme Catto
Cc: Finlay Scott Code A Paul Hylton Code A
Subject: Dr Jane Barton

Graeme,

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Regards

Paul

Paul Hylton Code A

From: Paul Philip (Code A
Sent: 24 Sep 2004 12:05
To: Professor Sir Graeme Catto
Cc: Finlay Scott (Code A); Paul Hylton Code A
Subject: Dr Jane Barton

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Regards

Paul

Paul Hylton Code A

From: Adam Elliott (Code A
Sent: 24 Sep 2004 15:11
To: Toni Smerdon Code A
Cc: Paul Hylton Code A ; Alison Thompson Code A Paul Philip Code A Code A IOC Team
Subject: RE: Dr Barton - IOC Hearing

Toni,

Further to yesterday's conversations, I can confirm that Mr Henderson is booked for 7 October and that he is awaiting instructions from the legal team.

We have booked the General Chiropractic Council which is located in Kings X - I am in negotiation with them as to the overall cost, however, I will hopefully manage to agree a very good deal for the GMC especially considering the shortness of time etc (hopefully the entire cost of the hearing (including the venue, catering etc, etc) will be under the £1500 mark)

We have confirmed a SHW and the Legal Assessor who will be Mr Tim Swan (1 Paper Buildings). Mr Swan is an extremely experienced legal assessor who though only sitting with the IOC for the first time in early 2004 has proven to be extremely sound, competent and knowledgeable with regard to Interim Orders.

A panel of 5 has been confirmed and they are:

Professor Norman MacKay
Dr Jack McCluggage
Dr Andy Stewart
Mrs Angela Macpherson
Mrs Rani Atma

They are all extremely experienced members of the IOC. Professor MacKay will chair, I spoke to Alison today as I had one concern namely that we did not have a female medical practitioner on the panel, she and I came to the conclusion that it was probably not necessary (bearing in mind the collective knowledge, skills and experience of the panel) but I do look to you for final direction.

The item will be going out this afternoon as Paul H is now in receipt of the referral from the President.

I think I've covered all the bases but do let me know if there is anything further you need me to do.

Thanks,

Adam

-----Original Message-----
From: Paul Philip Code A
Sent: 23 Sep 2004 11:48
To: Adam Elliott Code A
Cc: Paul Hylton Code A ; Toni Smerdon Code A ; Alison Thompson Code A
Subject: Re: Dr Barton - IOC Hearing

Dear all,

We need to get this case to IOC ASAP. If Roger cannot do the earliest date available then we should find someone else who can.

What is the earliest date this can go to the IOC and how much further would we have to wait for Roger to do this?

Paul

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Adam Elliott (Code A
To: Paul Philip Code A Toni Smerdon Code A
CC: Paul Hylton Code A Alison Thompson Code A
Sent: Thu Sep 23 12:15:50 2004
Subject: Dr Barton - IOC Hearing

Paul,

Roger Henderson, QC is only available on 7 October for the IOC hearing (he has a meeting with you and Toni on the 6th and is then not free until late October). Mr Henderson has to cancel three other appointments on that day but is content to do so.

Unfortunately there is no room availability either in Hallam Street or in 350 Regent's Place (this is due to two of the hearing rooms in 350 not being available during that week).

Hallam Street has the Council Chamber and Committee Room 3 taken up by the 'Brewer' case and Committee Room 2 is in use by the Health Committee for the two day hearing of Dr Cullen. The room was provisionally booked by the Registration Committee (who were not going to sit on those days), however, subsequent to that and prior to Mr Henderson being available the room is now needed by the Health Committee (the case originally listed in GPS, which will obviously no longer be available). The Council Chamber in the new building is being used for two PCC hearings.

The idea of using Committee Room 1 for the hearing in Hallam Street did occur but that would mean that there would be no lunch provision for the members sitting on the PCC or Health Committee and my understanding is that, that would not be acceptable.

Due to the urgency attached to this case and the need to have it heard in London, with Mr Henderson acting as GMC Counsel, the only other option that seems to be available is to have the case heard at an outside venue.

It would not be as expensive cost wise as an outside PCC as there is no need to provide space for Press/Public/Witnesses.(unless Dr Barton directs her hearing to be public, something that she has not done previously)

Mr Henderson's clerk has asked that I/we confirm this morning as to 7 October. I would be grateful if you could either agree to have the hearing held at an outside venue, or provide further direction as to looking for different Counsel and/or a different date for the IOC hearing.

In anticipation of the hearing going to an outside venue I will canvass availability of local hearing rooms this morning, but won't book anything until I receive further instructions from you.

Many thanks,

Adam

Dr Jane BARTON

Analysis concerning cases that have previously been seen by the GMC

Patient Name	Expert/Police information	Seen by IOC/PPC (inc. date)
Eva Page	• Expert Report – Dr Mundy • Expert Report – Professor Ford	PPC (30/8/02) IOC (19/9/02)
Alice Wilkie	• Expert Report – Dr Mundy • Expert Report – Professor Ford	PPC (30/8/02) IOC (19/9/02)
Gladys Richards	• Expert Report - Prof. Livesley • Expert Report – Professor Ford • Police Statement – Jane Barton • Police Interview – Dr Althea Lord (Consultant at Gosport War Memorial Hospital) • Police Interview – Philip Beed (Clinical Manager at Gosport War Memorial Hospital)	PPC (30/8/02) IOC (19/9/02) IOC (21/3/02) IOC (19/9/02)
Arthur Cunningham	• Expert Report – Dr Mundy • Expert Report – Professor Ford	PPC (30/8/02) IOC (19/9/02)
Robert Wilson	• Expert Report – Dr Mundy • Expert Report – Professor Ford	PPC (30/8/02) IOC (19/9/02)

Category 2 cases where expert evidence indicates that it may be properly arguable that Dr Barton's alleged conduct is capable of constituting spm

Patient Name	Expert/Police information	Seen by IOC/PPC (inc. date)
Victor Abbatt		
Dennis Amey		
Charles Batty		
Dennis Brickwood		
Charles Hall		
Catherine Lee		
Stanley Carby		
Walter Clissold		
Harry Hadley		
Alan Hobday		
Eva Page	• Expert Report – Peter Lawson	PPC (30/8/02) IOC (19/9/02)
Gwendoline Parr		
Edna Purnell		
Daphne Taylor		

To: Kevin Duce

From: Code A
Trainee Solicitor
Ext: Code A

Date: 16 September 2004

Subject: GMC v Jane Barton 4002044-0131

Documents for Barton

1 Level arch file with medical records for:

1.1 Gladys Richards

1.2 Arthur Cunningham

1.3 Alice Wilkie

1.4 Robert Wilson

1.5 Eva Page

2 2 x Level arch files of Hampshire Constabulary documents (witness statements etc)

3 2 x miscellaneous bundles

3.1 proceedings for the GMC Interim Orders Committee and the Hampshire Constabulary Documents

3.2 Documents relating to the Interim Orders Committee and the PPC

4 2 x files relating to Hampshire Constabulary v Dr Jane Barton

5 green GMC file

6 file relating to Ms Yeats v Dr Barton

7 file relating to Code A v Dr Barton

8 file relating to Jackson v Beed and Barton

9 file 'Dr Jane Barton (Screeners' file)'

10 file relating to CHI v Unknown

TELEPHONE MESSAGE PAD

FROM .....

TO .....

TIME/DATE .....

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Mike Gill Code A
- Regional Director of Public Health (S.E. Region)

Rachel Dixon (m) Code A
- Chief Medical Officer's office)

Simon Tanner (m) Code A
- Director of Public Health at Portsmouth Health Authority

Message taken by .....

Paul Hylton Code A

From: Code A
Sent: 30 Sep 2004 10:28
To: Code A
Subject: FW: Document2

Paul.. Please confirm receipt..DW.

From: Code A
Sent: 30 September 2004 11:20
To: Williams, David (DCI)
Cc: Code A
Subject: Document2

<<Doc2.doc>>

Paul Hylton Code A

From: Code A
Sent: 17 Sep 2004 14:29
To: Code A
Subject: RE: Operation Rochester

Mr HYLTON

Thankyou for your report updating the GMC's position.
I will deal with this during the course of the weekend, and will look to provide a statement covering the issues raised by Wednesday 22nd September.

Regards.
DW.

From: Paul Hylton Code A
Sent: 17 September 2004 15:40
To: Williams, David (DCI); Watts, Steve
Cc: Code A
Subject: Operation Rochester

Dear Detective Superintendent Williams

I have now had an opportunity to review the information disclosed to the GMC by Hampshire Police on 10 September 2004 relating to the 19 cases in which Hampshire Police, having received advice from medical and legal experts, have determined that the treatment by Dr Barton was "sub-optimal". Only one of those cases, that of Eva Page, has previously been considered by the GMC's Interim Orders Committee and Preliminary Proceedings Committee.

Of those 19 cases, it would appear that in the following 14 cases the information is such that a referral to the IOC may be appropriate:

Victor Abbatt
Dennis Amey
Charles Batty
Dennis Brickwood
Charles Hall
Catherine Lee
Stanley Carby
Walter Clissold
Harry Hadley
Alan Hobday
Eva Page
Gwendoline Parr
Edna Purnell
Daphne Taylor

It is the GMC's intention to seek referral of the information in these cases to the Interim Orders Committee, and, in the event that such a referral is made, to ensure that the hearing takes place expeditiously. It would also be the GMC's intention to put before the Interim Orders Committee information in relation to those cases which you consider are Category 3 cases, either in the form of a statement from yourselves or by disclosing more detailed information should you be in a position to disclose it.

The GMC has always recognised the need to ensure that we do not compromise the Police's investigations, and this will continue to be the case. However, it is also important that we present the Interim Orders Committee with as full a picture as is possible in respect of any threat that Dr Barton may pose to the public, in order that the Committee is best placed to ensure

that the public are protected. The GMC is therefore of the view that it would be of considerable assistance to our case before the Interim Orders Committee if we were able to present a statement from the Police giving as much information as it is prudent to disclose at this time in respect of the Category 3 cases. Clearly, these cases by their very nature raise issues of public safety over and above those raised by the Category 2 cases, and it is therefore important that the Interim Orders Committee are able to consider those cases, even if such consideration is limited at this time to a statement from Police confirming the number of cases under consideration and a brief outline of the nature of the allegations.

It is also important that the Committee is updated as to the current position of the other four cases it has previously considered, those cases being the cases of:

Alice Wilkie
Gladys Richards
Arthur Cunningham
Robert Wilson

This update can either be in the form of a separate statement or it can be incorporated into the statement on the Category 3 cases.

I am sure that you will appreciate the urgency of my request given the proximity of the hearing and the need to disclose the information we propose to put before the Committee to Dr Barton before the hearing takes place. Could you therefore please confirm either by return email or by telephone on Monday 20 September 2004 the mechanism by which we can expect to receive a statement.

Yours sincerely

Paul Hylton
General Medical Council
Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Paul Hylton Code A

From: Paul Hylton Code A
Sent: 23 Sep 2004 12:00
To: Code A
Cc: Paul Philip Code A; Peter Swain Code A
Subject: RE: Operation Rochester
Importance: High

David

It is likely to go ahead sometime w/c 4 October 2004, so I would need to disclose the information to Dr Barton's legal reps by 27/28 September at the latest.

I will probably have to make a disclosure in two parts, the info we have at the moment can be disclosed next week followed by your statement and any supporting documentation.

When you provide your statement can you please provide copies of the expert reports for the patients named below. The summaries we have are OK for my purposes, but it is likely that the IOC will want to have sight of the whole report for each patient.

Paul

-----Original Message-----
From: Code A
Sent: 22 September 2004 17:39
To: Code A
Subject: RE: Operation Rochester

Paul..

Apologies.. I have not lived up to my good intentions .. A busy period (Operational commitments) have not enabled me to complete this work..

I am now off for four 4 days having worked 10 consecutive..

You refer in your E mail to the proximity of the hearing.. but not the proposed date?..

Could you please let me know.. should you need to discuss my mobile number is Code A

I have kept my diary free for Monday 27th Sept to deal with this..

DW.

From: Paul Hylton Code A
Sent: 17 September 2004 16:30
To: Williams, David (DCI)
Subject: RE: Operation Rochester

Dear DS Williams

Thank you for your prompt response.

Paul

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From: Code A
Sent: 17 Sep 2004 14:29
To: Code A
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Yours sincerely

Paul Hylton
General Medical Council
Direct line: Code A

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General Medical Council
178 Great Portland Street London W1W 5JE
Tel: +44 (0) 20 7580 7642
Fax: +44 (0) 20 7915 3641

****

****

ul Hylton Code A

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Paul Hylton
General Medical Council
Direct line: Code A

General Medical Council
178 Great Portland Street London W1W 5JE
Tel: +44 (0) 20 7580 7642
Fax: +44 (0) 20 7915 3641

HAMPSHIRE Constabulary

Chief Constable Paul R. Kernaghan QPM LL.B MA DPM MCIPD

CONFIDENTIAL

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

Ms Louise Povey
General Medical Council
178 Great Portland Street
London
W1W 5JE

31 AUG 2004

27 August 2004

Dear Ms Povey

Operation Rochester – Investigation into deaths at Gosport War Memorial Hospital

I write on behalf of Detective Superintendent Williams to acknowledge receipt of your letter of the 26th of August 2004, regarding the above matter.

The content of your letter is receiving of fullest consideration and you can be sure that we will contact you in due course to discuss any pertinent issues that may arise.

If can be of any assistance in the mean time, please do not hesitate to contact me.

Code A

Nigel Niven
Detective Chief Inspector
Operation Rochester

26 August 2004

Confidential: First Class

Detective Chief Inspector David Williams
Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 ONA

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear DCI Williams

Operation Rochester – Investigation into Deaths at Gosport War Memorial Hospital

I write further to our exchange of e-mails and, in particular, your e-mail of 17 August 2004. Thank you for your continued assistance in this matter. I am very pleased to note that, subject to certain conditions, you are in a position to provide us with the information you have relating to 19 of the category two cases.

I confirm that we will review the information you supply and, if appropriate, make an application to the Interim Orders Committee. If an application is made to that Committee, the doctor and her representatives will be supplied with information upon which we intend to rely. The Interim Orders Committee usually sits in private but the doctor has a right to insist on a public hearing. It is rare that a doctor insists on a public hearing. There is no indication that the doctor in this case will insist on a public hearing, she has not done so at previous hearings and we have no reason to believe that her representatives would advise her to do so.

Publicity about the case is generally outside our control but the GMC shall not instigate publicity before or during any criminal trial.

I acknowledge that statements the GMC takes from witnesses who subsequently take part in any trial are discloseable to the defence. I confirm that the GMC will liaise with the police and inform you of the identity of proposed witnesses before we take statements.

In general terms, we are willing to confirm that we will not proceed to a public inquiry at the Professional Conduct Committee in relation to matters which are the subject of your investigation until the conclusion of that investigation or any criminal trial. However, as you are aware, the GMC also has statutory duties and any agreement to delay our dealing with this matter is subject to the police keeping us informed about the progress of the investigation and pursuing the investigation and prosecution within a reasonable time. We may proceed to the Professional Conduct

178 Great Portland Street, London W1W 5JE. Telephone 020 7580 7642. Fax 020 7915 3641
email gmc@gmc-uk.org. www.gmc-uk.org
Registered Charity No. 1089278

Committee if, for example, the police investigation is in abeyance for an indefinite period or is subject to unreasonable delay. If other matters concerning this doctor come to our attention (for example matters relating to health, performance or conduct) which do not form part of your investigation we may proceed to investigate and adjudicate in relation to those matters.

As we have not yet seen the material, I do not wish to raise an expectation that we shall definitely proceed to the Interim Orders Committee. Therefore, I would ask that you exercise caution in this regard in your communication with the families, their representatives, the Strategic Health Authority, the Primary Care Trust or any other interested party.

I note that you will seek the consent of witnesses to release statements to us. I look forward to receiving the material during the week commencing 30 August 2004.

Thank you again for your helpful approach in this case.

Yours sincerely

Code A

Louise Povey
Manager, Special Projects

Code A

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mrs Sandra Howell

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Howell

Dr Jane Barton

You will be aware that Hampshire Police are currently carrying out an investigation into the circumstances surrounding the deaths of a number of patients, occurring principally during the late 1990's, at Gosport War Memorial Hospital, Hampshire. You will also be aware that during the course of those investigations Hampshire Police have had cause to refer to the GMC matters concerning the treatment of a number of patients by Dr Jane Barton, some of who have sadly died. This information is due to be considered by the GMC's Professional Conduct Committee at a public hearing once the Police and GMC investigations have been completed.

It is the GMC's normal practice when working alongside a Police investigation to put our investigations on hold so that we do not inhibit the Police investigation. However, even though we have a duty not to inhibit a Police investigation, we are always mindful of our overriding responsibility to protect patients. Therefore, on 7 October 2004 the GMC's Interim Orders Committee will consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest, for Dr Barton's registration to be restricted whilst Hampshire Police carry out its investigation. If the Interim Orders Committee is of the view that a restriction is appropriate, it can issue an order to suspend or impose conditions on Dr Barton's registration, for a period not exceeding eighteen months.

The Interim Orders Committee will meet in private. However, the GMC is under a statutory duty to publish the outcome of all Interim Orders Committee hearings. It is our usual practice to do so by placing the outcomes of hearings on our website, the address of which is www.gmc-uk.org.

I will be the GMC caseworker for our investigation concerning the information from Hampshire Police regarding Dr Barton's treatment of patients at Gosport War Memorial Hospital. If you have any questions about the GMC's investigation or process please do not hesitate to contact me.

Yours sincerely

Code A

Paul Hylton
Conduct Case Presentation Section
Direct Line: **Code A**

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mrs Sandra Taylor

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Taylor

Dr Jane Barton

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Yours sincerely

Code A

Paul Hylton
Conduct Case Presentation Section
Direct Line: **Code A**

2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 8001 Fax 020 7189 5001
email gmc@gmc-uk.org www.gmc-uk.org

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mr Martin Chivers

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Chivers

Dr Jane Barton

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I will be the GMC caseworker for our investigation concerning the information from Hampshire Police regarding Dr Barton's treatment of patients at Gosport War Memorial Hospital. If you have any questions about the GMC's investigation or process please do not hesitate to contact me.

Yours sincerely

Code A

Paul Hylton
Conduct Case Presentation Section
Direct Line: Code A

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mrs Rita Carby

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Carby

Dr Jane Barton

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Paul Hylton
Conduct Case Presentation Section
Direct Line: Code A

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5 October 2004

Mr Anthony Brickwood

Code A

GENERAL MEDICAL COUNCIL

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Dr Jane Barton

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Paul Hylton
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5 October 2004

Mrs Lesley Lowe

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Lowe

Dr Jane Barton

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5 October 2004

Mrs Pauline Gilmore

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Gilmore

Dr Jane Barton

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5 October 2004

Mr John Taylor

Code A

GENERAL MEDICAL COUNCIL

Protecting patients guiding doctors

Dear Mr Taylor

Dr Jane Barton

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5 October 2004

Mr James Ripley

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Ripley

Dr Jane Barton

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Direct Line: Code A

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5 October 2004

Miss Alexander Moore

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Miss Moore

Dr Jane Barton

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Paul Hylton
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Direct Line: **Code A**

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5 October 2004

Mrs Rita Hoare

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Hoare

Dr Jane Barton

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Direct Line: Code A

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email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mr Bernard Page

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Page

Dr Jane Barton

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5 October 2004

Mr Colin Parr

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

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Paul Hylton
Conduct Case Presentation Section
Direct Line: **Code A**

In reply please quote case reference no. PCH/2000/2047

6 October 2004

Mr Michael Hobday

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Hobday

Dr Jane Barton

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Direct Line: **Code A**

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5 October 2004

Mrs Diane Harcourt

Code A

GENERAL MEDICAL COUNCIL

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Dear Mrs Harcourt

Dr Jane Barton

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2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 3001 Fax 020 7189 5001
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In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mrs Sandra Howell

Code A

GENERAL MEDICAL COUNCIL

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Dear Mrs Howell

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5 October 2004

Mrs Sandra Taylor

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5 October 2004

Mr Martin Chivers

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I will be the GMC caseworker for our investigation concerning the information from Hampshire Police regarding Dr Barton's treatment of patients at Gosport War Memorial Hospital. If you have any questions about the GMC's investigation or process please do not hesitate to contact me.

Yours sincerely

Code A

Paul Hylton
Conduct Case Presentation Section
Direct Line: **Code A**

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mrs Rita Carby

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Carby

Dr Jane Barton

You will be aware that Hampshire Police are currently carrying out an investigation into the circumstances surrounding the deaths of a number of patients, occurring principally during the late 1990's, at Gosport War Memorial Hospital, Hampshire. You will also be aware that during the course of those investigations Hampshire Police have had cause to refer to the GMC matters concerning the treatment of a number of patients by Dr Jane Barton, some of who have sadly died. This information is due to be considered by the GMC's Professional Conduct Committee at a public hearing once the Police and GMC investigations have been completed.

It is the GMC's normal practice when working alongside a Police investigation to put our investigations on hold so that we do not inhibit the Police investigation. However, even though we have a duty not to inhibit a Police investigation, we are always mindful of our overriding responsibility to protect patients. Therefore, on 7 October 2004 the GMC's Interim Orders Committee will consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest, for Dr Barton's registration to be restricted whilst Hampshire Police carry out its investigation. If the Interim Orders Committee is of the view that a restriction is appropriate, it can issue an order to suspend or impose conditions on Dr Barton's registration, for a period not exceeding eighteen months.

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Yours sincerely

Code A

Paul Hylton
Conduct Case Presentation Section
Direct Line: **Code A**

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mr Anthony Brickwood

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Brickwood

Dr Jane Barton

You will be aware that Hampshire Police are currently carrying out an investigation into the circumstances surrounding the deaths of a number of patients, occurring principally during the late 1990's, at Gosport War Memorial Hospital, Hampshire. You will also be aware that during the course of those investigations Hampshire Police have had cause to refer to the GMC matters concerning the treatment of a number of patients by Dr Jane Barton, some of who have sadly died. This information is due to be considered by the GMC's Professional Conduct Committee at a public hearing once the Police and GMC investigations have been completed.

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Yours sincerely

Code A

Paul Hylton
Conduct Case Presentation Section
Direct Line: **Code A**

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mrs Lesley Lowe

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Lowe

Dr Jane Barton

You will be aware that Hampshire Police are currently carrying out an investigation into the circumstances surrounding the deaths of a number of patients, occurring principally during the late 1990's, at Gosport War Memorial Hospital, Hampshire. You will also be aware that during the course of those investigations Hampshire Police have had cause to refer to the GMC matters concerning the treatment of a number of patients by Dr Jane Barton, some of who have sadly died. This information is due to be considered by the GMC's Professional Conduct Committee at a public hearing once the Police and GMC investigations have been completed.

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Yours sincerely

Code A

Paul Hylton
Conduct Case Presentation Section
Direct Line: **Code A**

In reply please quote case reference no. PCH/2000/2047

5 October 2004

Mrs Pauline Gilmore

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mrs Gilmore

Dr Jane Barton

You will be aware that Hampshire Police are currently carrying out an investigation into the circumstances surrounding the deaths of a number of patients, occurring principally during the late 1990's, at Gosport War Memorial Hospital, Hampshire. You will also be aware that during the course of those investigations Hampshire Police have had cause to refer to the GMC matters concerning the treatment of a number of patients by Dr Jane Barton, some of who have sadly died. The information is due to be considered by the GMC's Professional Conduct Committee at a public hearing once the Police and GMC investigations have been completed.

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Yours sincerely

Code A

2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 8001 Fax 020 7189 5001
email gmc@gmc-uk.org www.gmc-uk.org

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

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 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

RECEIVED
- 5 OCT 2004

SENDING CONFIRMATION

DATE : 5-OCT-2004 TUE 13:22
NAME : FPD
TEL : Code A

PHONE : Code A
PAGES : 2/2
START TIME : 5-OCT 13:21
ELAPSED TIME : 00'30"
MODE : ECM
RESULTS : OK

FIRST PAGE OF RECENT DOCUMENT TRANSMITTED...

Fax - Confidential

To Mr Ian Barker – The MDU
Fax number 020 7202 1663
From Paul Hylton
Direct Dial Code A
Direct fax

No. of pages (inclusive) 2 *Time* *Date* 05/10/04

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

In reply please quote PCH/2000/2047

Your ref. ISPB/TOC/0005940/Legal

By Fax and first class post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

5 October 2004

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

2nd Floor, Regents Place, 350 Euston Road, London, NW1 3JN. Telephone 0845 357 8001. Fax 020 7189 [illegible]
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. [illegible]

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

By Special Delivery and First Class Mail

24 September 2004

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

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 (fax no 020 7915 7406).

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 Elliot, 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

Code A

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 PPD
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

In reply please quote PCH/2000/2047

Special Delivery

30 September 2004

Dr Jane Ann Barton

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Dr Barton

Thank you for your letter of 27 September 2004 confirming that you intend to attend the IOC hearing on 7 October 2004. Further to my letter of 24 September 2004, please find enclosed a copy of the item that will be considered by the Committee at that hearing.

It may be helpful if I bring two matters to your attention concerning the information. You will note that in the witness statement from Hampshire Police they state that they have referred 19 cases to the GMC which in their view are what they have classified as Category two cases. However, having reviewed the summary reports, it was the GMC's view that in five of those cases the information available at this time did not suggest that those cases should be considered by the IOC. You will also note at the end of the item index that copies of the patient records are not in the enclosed papers, but that they will be available at the hearing. The records, as I am sure that you are aware, are voluminous and it is our practice in such situations to have the records available at the hearing should either the Committee or the doctor require them. That said, if after considering the enclosed information you are of the view that you require a copy of the records, I will arrange for you to receive a copy expeditiously.

The GMC will be moving from its current premises into new offices on 1 October 2004. Unfortunately, this does mean that it is unlikely we will not be able to provide you with a copy of the records, should you require them, before Monday 4 October 2004. If you do require a copy, or if the MDU require a copy, could you please telephone me either tomorrow before 12:00 pm on Code A, or on Monday 4 October on my new direct line number Code A.

Yours sincerely

Code A

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

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

E:\Committee\Voc\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 – Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to the Committee Section FPD
Fax Code A

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

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email gmc@gmc-uk.org www.gmc-uk.org

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

CPT DOCUMENTS
END

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

12 September, 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

On 29 August 2002 the Preliminary Proceedings Committee considered the allegations about your conduct described in our letter of 11 July 2002, and the observations set out in your solicitor's letter of 27 August 2002.

The Committee determined that a charge should be formulated against you on the basis of the information and that an inquiry into the charge should be held by the Professional Conduct Committee.

In considering this case, the Committee noted that the case related to five patients between the ages of 75–91 who were attending Gosport War Memorial Hospital, mainly for rehabilitation. One person (Mrs Lack) who was an experienced nurse in elderly care was concerned about the treatment of her elderly mother (Mrs Richards) in the ward, which precipitated the reviews of other patients. The Committee noted the fairly brief report of Dr Mundy, and Professor Ford's report which looked at all five cases. It noted the background to the case as a whole, which was that you were a visiting clinical assistant who was responsible for the day-to-day management of these five cases. It noted that overwork had apparently affected patient care.

It noted that in the case of Mrs Richards she had lost a hearing aid and her spectacles, and was brought in in an agitated state, probably because of sensory deprivation. She became ambulant with a Zimmer, but her hip replacement became dislocated following a fall. This patient was prescribed the same set of drugs which was used in each of the other cases: Oramorph, hyoscine and midazolam. It noted that some patients had up to 60–80 mg in 24 hours via subcutaneous injection with a syringe driver.

The Committee noted that Mrs Richards received no foods or fluids between 18 – 21 August and died because of the combination of lack of nutrition and sedation. The Committee considered that the administration of these drugs may have shortened

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Registered Charity No. 1089278

the patient's life. It noted Professor Ford's comments about the prescribing regime. It noted with concern that the medical records are not signed regarding the subcutaneous drugs regime and it noted the pattern in which an elderly group of patients were the subject of apparently reckless and inappropriate prescribing. The Committee agreed that death appeared to have been precipitated if not caused by the drug regime in each case.

In considering this case, the Committee was mindful that palliative care is now a well-developed clinical area. If death is accelerated as a result of carefully titrated, good symptoms control, then as a side-effect it may be acceptable. This did not appear to be the case here, and the Committee was of the view that the matter unequivocally needs to be tested by the Professional Conduct Committee. The Committee was concerned that you appear to have moved patients very quickly onto a regime where they were receiving terminal care, and ignored the recommendations regarding doses in the BNF, rapidly prescribing excessive doses.

Every effort is made to give reasonable notice of the date of a Professional Conduct Committee hearing. Notice of the date and time of the proposed inquiry, and of the exact terms of the charge to be considered, will be sent to you by the Solicitor to the Council at least twenty-eight days before the date fixed for the hearing. No date has yet been fixed for the hearing of your case. If there are any particular dates which you would prefer the GMC to avoid, could you please let Michael Keegan know in writing as soon as possible.

If you intend to consult your medical defence society, your professional association, or take other legal advice, you should do so without delay. It is in your best interests to begin as soon as possible the preparation of your case for the Professional Conduct Committee hearing, notwithstanding that the exact date and time of the hearing have not yet been specified. You should also notify your advisers as soon as you receive the formal notice of the date of the inquiry.

Yours sincerely

Code A

Vanessa Carroll
Assistant Registrar

c.c. The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London SE1 8PJ
(Your Reference: ISP/B/TOC/6000070/Legal)

Louise Povey Code A

From: Code A
Sent: 17 Aug 2004 15:39
To: Code A
Subject: RE: OP Rochester.

Louise.

Thankyou.

I have received the advice from RDS of the CPS who agrees that subject to the conditions that he suggests we can reveal the information relating to 19 of the category 2 cases without compromising the ongoing police investigation.

We would therefore seek agreement from the GMC in respect of the following conditions.

1.That the information is supplied towards a private IOC hearing.

2.That there is no adverse publicity prior to or during any criminal procedings.

3.Statements taken by GMC from witnesses who are subsequently witnesses in criminal procedings will be disclosable.

4.GMC should liaise with the police informing them of identity of proposed witnesses before taking statements.

5.Permission will be sought from Category 2 case witnesses to reveal their statement etc to the GMC.

6.GMC should not institute further discipliniary proceedings until any criminal investigation and criminal trial have been concluded.

In addition Steve WATTS has indicated that the following will apply:-

1. 'I take the view that it is in the public interest to disclose to the GMC those documents which fall within category 2, which having been reviewed by Matthew Lohn we are satisfied have no potential to be the subject of a prosecution'.

2. Prior to that disclosure, we must contact the families concerned and explain the situation, seeking their approval for that disclosure.

3. This decision should also be subject of a family group bulletin.

4. This decision to be communicated to Ann Alexander.

5. This decision to be communicated to the SHA & PCT.

6. CMO to be informed.

7. Ian Barker, representing DR Barton to be informed.

8. In view of the fact that the DCC has taken an interest in this matter, please inform ACC SO of our decision and DCC prior to actioning. This will allow them to raise objections if they wish to do so.

Louise, apologies if this seems a laborious process but it is necessarily so. Wider consultation is necessary to manage the impact of the decision and consider representations from key stakeholders.

Deputy Chief Constable has specifically requested to have the opportunity to make representations regarding the issue of release to the GMC.he returns from leave on the 24th August 2004.

I anticipate that the material will be delivered to your offices during the week commencing Monday 30th August 2004.

Regards.

Dave WILLIAMS.Det Supt.

From: Code A
Sent: *17 August 2004 16:51*
To: *Williams, David (DCI)*
Subject: *FW: OP Rochester.*

Dear Dave
I had a useful conversation with with Robert Dryborough Smith of the CPS late last Thursday. The gist of it was that his advice to the police will be that you can release the category 2 material to us. He wanted confirmation that the IOC was held in private (although he appreciates that Dr Barton will see the material) and that we wouldn't go to a full blown public inquiry without reference to you. He indicated that his advice would go out last Thursday/Friday. Have you received the advice? If so, when may we receive the material?

I hope that the issues relating to the small number of category 2 cases which may become category 3 cases do not delay us as there is plenty for us here to get on with in relation to the category two cases which we know will stay in category 2.

I look forward to hearing from you.

Regards
Code A

-----Original Message-----
From: Code A
Sent: 12 Aug 2004 15:05
To: Code A
Subject: RE: OP Rochester.

Dear Dave
I have a call out to Robert Dryborough-Smith. I will let you know the outcome.

We are a month on from our meeting and do not seem to be any nearer getting the category 2 material.

Could you please tell me when we can expect to receive Steve Watts' statement?. That would be most helpful as in the absence of the category 2 material, we may proceed to our Interim Orders Committee assisted by the attendance of Steve. May we please have it by Thursday 19 August 2004?

Yours
Louise

-----Original Message-----
From: Code A

[mailto Code A
Sent: 07 Aug 2004 09:12
To: Code A
Subject: RE: OP Rochester.

Louise..

The CPS representative is Senior Lawyer Robert DRYBOROUGH- SMITH (Central Caswork Directorate Ludgate Hill). A contact from yourself to explain issues for the GMC would probably help speed the process.
We have Mathew LOHN'S report although he has raised 'issues' in respect of the categorisation seven cases currently assessed as 2's.
I am meeting with him next Thursday 12th August to discuss.
We need to resolve the issues with Mathew because those cases are likely to be the more interesting from the GMC's perspective.

Whilst I appreciate the concerns with regard to patient protection, it seems to me that the risks in respect of Dr BARTON'S continuing practice have been ameliorated by the voluntary conditions in place.

Have you considered taking a statement or receiving a formal report from the primary trust? detailing the exact conditions, and evidencing precisely the prescriptions being written up by Dr BARTON. This would not compromise our investigation and would demonstrate that the GMC were indepentently assessing ongoing risk.

Regards.

Dave WILLIAMS.

From: Louise Povey Code A
Sent: 05 August 2004 17:33
To: Williams, David (DCI)
Subject: RE: OP Rochester.

Dear Detective Superintendent Williams

Helpful areas to include in the statement are:
1. Job title/responsibility/background etc
2. Involvement in the investigation.
3. Nature and seriousness of the investigation - numbers of cases, details of the categories, likely charges etc.
4. The reason why more detailed information cannot be revealed at this stage.
5. Future action and timetable by the police/CPS.
6. An acknowledgement of/reference to public protection issues. (For information, we know there is a current undertaking but it is voluntary and there is a risk that the doctor may change employer/prescribe outside the terms of the undertaking).

Can you tell me what is holding the CPS up? Are they waiting for something in particular (I assume they now have Matthew Lohn's report) or is it simply pressure of work? Do you have a contact name/number at the CPS so that I could speak to them direct.

I am sorry to pester but, as you know, we have concerns about patient protection. The immediate decision for us is whether to proceed to our Interim Orders Committee now with somewhat limited information or wait for the release of the category 2 material which has been promised since we last met. We would prefer the latter but as time rolls on we may have to do the former. We are more likely to secure patient protection with the category 2 material.

I look forward to hearing from you.

Louise Povey
Code A

-----Original Message-----
From: Code A
[mailto
Sent: 03 Aug 2004 13:51
To:
Cc: Code A
Subject: RE: OP Rochester.

Dear Mrs POVEY

Steve WATTS is currently taking Annual Leave.. He returns to work next week..
I will discuss the outline of his statement and forward to you asap.
Can you please confirm subject areas/identify particular issues that would assist your investigation.
I await the observations of the CPS before releasing the category 2 material.
As soon as the final decision is made, and assuming that disclosure is agreed I will arrange immediate delivery.

Regards.

Dave WILLIAMS.
Det Supt.

From: Louise Povey (7915 3732) Code A
Sent: 29 July 2004 13:19
To: Williams, David (DCI)
Subject: FW: OP Rochester.

Dear Detective Superintendent Williams

Is there now a decision about releasing the category 2 material? If the decision is to release the material, when might I receive it?

May we please have the outline of DCS Watts' intended statement.

Thank you for your assistance.

Yours
Louise Povey
Code A

-----Original Message-----
From: Louise Povey (7915 3732)
Sent: 22 Jul 2004 13:00
To: Code A
Subject: RE: OP Rochester.

Dear Detective Superintendent Williams

Thank you for this. I look forward to hearing from you early next week.

Yours

Louise Povey

-----Original Message-----
From: [mailto Code A
Sent: 21 Jul 2004 08:31
To: Code A
Subject: OP Rochester.

Dear Mrs POVEY

Thank you for your letter dated 13th July 2004 and accompanying note of our meeting of 6th July 2004.
Apologies for the slight delay in responding.

Firstly may I agree the accuracy of your note of our meeting.

In addition I can now inform you that Mathew LOHN completed his quality assurance work yesterday 20th July and we expect his reports in respect of the category 2 cases this week. He has agreed the findings of the Clinical team for 54 of those cases. However he has raised the status of 6 of the cases into the 3 category, and these will be subject to further discussion. It is likely that OP ROCHESTER will also investigate the circumstances surrounding the 6 further cases.

Subject to ongoing discussion with Mathew LOHN this is likely to raise the number of cases in the 3 category to 15.

I had a further meeting with Steve WATTS yesterday, and we are both in agreement that in the absence of strong legal rationale for withholding the category 2's we will be releasing them to the GMC as soon as possible. I hope that this decision can finalised early next week and that we can deliver to the GMC the relevant documents.

I confirm that the following information has been received from the local healthcare trust in respect of conditions pertaining to Dr BARTON.

Dr Barton has undertaken not to prescribe benzodiazepines or opiate analgesics from 1 October 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.

I have confirmed that these conditions still applied on 6th July 2004 with Hazel BAGSHAW the Pharmaceutical advisor for the local Healthcare trust. Over a 13month period from April 2003 Dr BARTON had written a total of 20 prescriptions

all for 2mg Diazepam to relatives of deceased, and had not prescribed any Diamorphine, morphine or other controlled drug.

Finally, I am meeting with Steve WATTS this Friday to discuss OP ROCHESTER. He is out of force at the moment. We will consider the outline of his statement to the GMC and let you know on Friday what he is prepared to say.

Regards.
Dave WILLIAMS. Det Supt.

General Medical Council
178 Great Portland Street London W1W 5JE
Tel: +44 (0) 20 7580 7642
Fax: +44 (0) 20 7915 3641

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178 Great Portland Street London W1W 5JE
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****

****

13 July 2004

Detective Chief Inspector David Williams
Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 ONA

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear DCI Williams

Operation Rochester – Investigation into Deaths at Gosport War Memorial Hospital

I write further to our meeting on 6 July 2004 and our subsequent telephone conversation on 8 July 2004.

I note from our brief telephone conversation that the CPS requires more information, including Matthew Lohn's report, before deciding whether to agree to the release of the category 2 material. Would you please indicate when the CPS decision on this point is likely to be made.

As things stand at present, we need to decide whether to refer Dr Barton to the IOC. I note that DCS Watts is willing to provide a statement or attend an IOC. It would assist us greatly if you could please provide a draft statement from DCS Watts indicating what information he is willing to provide to that Committee.

At the time of writing, I have not received your note of the meeting. I enclose my note, which I hope can be agreed.

Thank you for your assistance so far. I look forward to hearing from you.

Yours sincerely

Code A

Louise Povey
Manager, Special Projects

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmcq@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Note of meeting between the GMC and Hampshire Police at Great Portland St on 6 July 2004 regarding Dr Jane Barton (Operation Rochester).

Present:
DCS Steve Watts
DCI Dave Williams
Louise Povey
Toni Smerdon
Paul Hylton

1. The Police confirmed that, subject to their responsibilities as criminal investigators, they are willing to cooperate with the GMC. Both the Police and the GMC wish to ensure that the public are protected. The GMC's immediate concern is the ability to investigate the case and consider referral to the IOC.

2. The Police are unable to release certain information at present largely because they wish to avoid prejudice to their investigation. They are aware that information released to the GMC will be disclosed to Dr Barton. They wish to avoid disclosing information to Dr Barton before she is interviewed. The Police interview of Dr Barton is likely to take place in August/September 2004. The Police enquiries also concerned other individuals aside from Dr Barton and they are wary of disclosing any information to Dr Barton that might compromise those further investigations.

3. The Police have divided the cases concerning Dr Barton into 3 categories:

   i. Category 1 – Optimal care with no cause for concern.

   ii. Category 2 – Sub-optimal care (57 cases at present, possibility of 3 more being added).

   iii. Category 3 – Negligent care/cause of death unknown (9 cases).

4. The Police have engaged Mathew Lohn of Field Fisher Waterhouse to quality assure the Category 2 cases to ensure that the medical experts have examined all of the circumstances of the treatments. The quality assurance exercise is due to be completed by 16 July 2004. The Police have forwarded some of the information to the GMC previously. However, the experts' reports have not been forwarded to the GMC. Subject to CPS approval, the Police will agree to these cases being disclosed to the GMC. The GMC will then be in a position to investigate the issue of substandard care. The Police will also seek CPS approval for the GMC to use the Police's experts for the GMC case. The CPS will decide if Dr Barton's interview should include questions about Category 2 cases.

5. The GMC said that it wishes to consider the Category 2 cases as soon as possible with a view to referring the matter to the IOC. The Police remain willing to provide a statement for or attend an IOC. We discussed the limited nature of an application to IOC without the category 2 material but that is something the GMC will consider if the CPS consent is not forthcoming.

6. In the event that the CPS do not agree to disclose the category 2 material at this stage, the Police confirmed that category 2 and 3 material could be released after the August/September 2004 interview with Dr Barton.

7. The Police reported that Dr Barton is subject to restrictions locally regarding her prescribing, and that audits by the Trust had shown that she had adhered to those restrictions. The Police will send an email detailing the restrictions. The Trust's contact in that regard is Hazel Bagshaw, Pharmaceutical Advisor. The Police noted that the CHI report also raised questions regarding systems failures, particularly regarding the checking of Dr Barton's prescribing patterns.

8. Four of the Category 3 cases are expected to be with the CPS by the end of September 2004. The remaining five Category 3 cases are expected to be with the CPS by the end of 2004. The families of the patients in those case are represented by Alexander Harris Solicitors.

9. The Police are aware that one of the Category 3 cases is mentioned in the Baker report. If the GMC were to succeed in obtaining approval from the CMO for the use of the source material used in compiling the Baker report, then the Police would wish the GMC to liaise with them before carrying out any investigations to ensure that the criminal cases are not compromised.

10. DCI Williams is the main point of contact for the GMC.

Louise Povey

To 8-7 Dave Williams

+ CPS say they need FFWS advice & more particulars about the Cat 2 before deciding whether to agree to release the Cat 2 Material.
+ Satk will send a note of the meeting tomorrow.

1606

To Paul Philip } alerted by email
cc Paul Hylton } about meeting 6/7/04
Findlay Scott
Christine Couchman
OPCE
[redacted]
Toni Smendon 05 JUL 2004

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Tel: 0845 0454545

Fax: 01962 871204

Telex: 47361 HANPOL

Paul R Kernaghan
QPM LLB MA DPM MCIPD
Chief Constable

Your ref:

Our ref: CC/smg

2 July 2004

RECEIVED
- 6 JUL 2004

Mr Findlay Scott
Chief Executive
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear **Code A**

Re: Operation Rochester - Gosport War Memorial Hospital

Our telephone conversation on 23 June 2004 refers. I have raised your points with Detective Chief Inspector Williams and have set out his response below.

A clinical team of experts in toxicology, general medicine, palliative care, geriatrics and nursing have reviewed a total of 93 cases referred to OP ROCHESTER either by family members, through the family group solicitors, or through separate review undertaken by Professor Richard BAKER on behalf of the Chief Medical Officer Sir Liam DONALDSON.

The clinical team have highlighted 9 cases of serious concern of deaths of patients at the Gosport War Memorial Hospital between 1996 and 1999. (Negligent care that is to say outside the bounds of acceptable clinical practice, the cause of death being unclear). This has been a screening process as opposed to the production of evidence in accordance with a strategy agreed between the SIO Steve WATTS and the CPS.

We are effectively investigating the nine highlighted cases, which will be assessed by further experts who will provide evidential statements as to whether the care afforded to these patients was grossly negligent to a degree that will support a criminal prosecution.

Four cases will be fast-tracked to CPS by the end of September 2004.

It follows that Dr BARTON will be interviewed under caution in August/September 2004.

Once that has been done, the requirement to withhold the detail of the information from the GMC ceases (If we provide them with the information beforehand for the purposes of GMC hearing then they are obliged to reveal the information to Dr BARTON) which could compromise police interviews.

Mr WATTS has stated previously to the GMC that he is content to attend an Interim Order Hearing to give an overview of the police investigation to date, and that offer still stands.

I recently met with the Deputy Chief Executive of the Fareham and Gosport primary healthcare trust Mr Alan PICKERING (11.6.2004) who gave reassurances in respect of Dr BARTONS ongoing prescription of Opiates. Both the Healthcare Trust and Strategic Health Authority have a voluntary arrangement with Dr BARTON that her prescription of Opiates and Benzodiazapines are supervised at the time by another GP. The prescription levels are furthermore independently monitored through Healthcare Trust IT systems.

Given the comments of the Chief Executive of GMC that this arrangement no longer stands I am in the process of confirming the current arrangements, however it is my belief that they still stand.

Dr BARTON has previously appeared before the GMC Interim Orders Committee on the 21st March 2002 and 19th September 2002, in respect of similar allegations surrounding her prescription of Opiates at Gosport War Memorial Hospital, and following disclosure of papers relating to earlier police investigations. On both of those occasions the IOC considered that 'it was not necessary for the protection of members of the public, in the public interest or Dr BARTONS own interests to make an order affecting her registration.'

I have E mailed Mrs POVEY of the conduct case section of the GMC offering to meet her next Tuesday morning 6th July to discuss the current situation.

I think we both recognise that maintaining the confidence of the general public, and that of certain relatives, is a difficult dilemma in cases such as this. I trust the information supplied will assist you and I would highlight DCI Williams' liaison with Mrs Povey of your staff. I look forward to the time when the CPS have issued an authoritative direction in relation to prosecution or non prosecution. Such a development would allow us to proceed in a more open and regulated manner. Subject to our responsibilities as criminal investigators, we are keen to cooperate with your organisation with a view to safeguarding the public interest.

Code A

Paul Kernaghan
Chief Constable

Lais Hungria Code A

From: Paul Hylton Code A
Sent: 05 Jul 2004 10:40
To: Lais Hungria Code A
Subject: RE: Hampshire Constabulary - letter re Dr Barton

Lais

The Police are coming here to have a meeting with Louise Povey, Paul P, Toni Smerdon and myself at 9 am tomorrow morning.

Paul H

-----Original Message-----
From: Code A Code A
Sent: 05 Jul 2004 10:36
To: Paul Philip (Code A); Paul Hylton (Code A
Cc: Christine Couchman Code A Janice Barratt Code A
Subject: FW: Hampshire Constabulary - letter re Dr Barton

Paul P and Paul H

This is to let you know that we have received this morning a letter from the Chief Constable following his conversation with Finlay. They mention a meeting with the GMC (they emailed Louise Povey about it) tomorrow 6 July.

Lais

-----Original Message-----
From: Paul Philip Code A
Sent: 17 Jun 2004 18:04
To: Finlay Scott
Cc: Lais Hungria Code A Paul Hylton Code A
Subject: FW: Hampshire Constabulary - re Barton

Finlay,

You agreed to contact this chap early next week regarding the case of Dr Barton which is being investigated by the police presently.

Paul, could you provide a resume of the state of play on the Barton case for Finlay please.

Thanks

Paul

-----Original Message-----
From: Peter Steel Code A
Sent: 17 Jun 2004 16:08
To: Paul Philip Code A
Subject: Hampshire Constabulary - re Barton

Paul Kernaghan
Chief Constable
Hampshire Constabulary

Tel: 0845 045 4545

Note of telephone calls on 15 June 2004

Re Barton

Spoke to an administrator at Hampshire police. DCS Steve Watts (who Peter wrote to on 5 May) is on a course until November 2004. It is likely that is why we have had no response. In his place is DCS Ray Webb. Someone will call be back re operation Rochester.

Rang again and spoke with DC Kate Robinson. Explained that we needed a response to our 5 May 2004 letter. Was conciliatory and explained that there will be a further letter coming out asking for a detailed response – we understand the police's position but we both have statutory duties etc. Any more information they could give us would be helpful as we need to ensure public protection and are considering referring this to IOC again.

Someone will call me next Thursday/Friday

Louise Povey

1-7.

Contact Now DC | Dave Williams

Code A

Police Contacts

Cards given to Linda Quinn 30.9.03.

HAMPSHIRE CONSTABULARY
Not Proof of ID

Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Detective Chief Superintendent
Steve Watts MSc, BSc(Hons), MCMI
Head of CID

Code A

HAMPSHIRE CONSTABULARY
Not Proof of ID

Major Crime Investigation Team
Western Area Headquarters
12-18 Hulse Road
SOUTHAMPTON
Hampshire
SO15 2JX

Nigel Niven
Detective Inspector

Code A

See HC letter of 21.4.04 for new DSIO.

Toni Smerdon Code A

From: Francesca Compton (Code A) on behalf of Peter Steel (Code A)
Sent: 30 Apr 2004 14:47
To: Paul Philip (Code A)
Cc: Toni Smerdon (Code A)
Subject: Dr Barton - letter to the police

Dear Paul

I attach the proposed letter to the police in the above case. If you are happy with it, please let Toni know and she will make sure it get sent out.

Regards,
Peter

0430 - let to dsi watts.doc

Paul

Toni is drafting your response on this. If you agree to the letter, she'll send it out on Peter's behalf.

Code A

4/5/04

file - Gen Advice 2004

Our Ref: PS/PCC/Barton
Your Ref: Op Rochester

5 May 2004

Detective Chief Superintendent Steve Watts
Head of CID
Police Headquarters
West Hill
Romsey Road
Winchester
Hampshire SO22 5DB

GENERAL
MEDICAL
COUNCIL
Protecting patients
guiding doctors

Dear DCS Watts

Operation Rochester – Investigation into Deaths at Gosport War Memorial Hospital

I am a Solicitor and Principal Legal Advisor at the General Medical Council. I am writing in relation to the ongoing police investigation into possible criminal charges concerning deaths at Gosport War Memorial Hospital.

As you know from discussions with officers at the GMC, we are also investigating conduct issues concerning Dr Jane Barton arising out of the same facts as those which refer to your investigation.

GMC Involvement

The case against Dr Barton began in July 2000 when your force began an investigation into the circumstances surrounding the death of Gladys Richards, a geriatric patient at Gosport War Memorial Hospital ('the hospital'). The investigation was subsequently extended to four other deaths, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson and Eva Pegg.

In February 2002, the Crown Prosecution Service decided against a criminal prosecution. At this point the relevent papers were disclosed to the GMC to decide on any issues of serious professional misconduct or seriously deficient performance. In August 2002, the case was referred by the GMC's Preliminary Proceedings Committee for hearing before the Professional Conduct Committee ('PCC').

The case has been referred on 3 occasions (June 2001, March 2002 and September 2002) for consideration of whether Dr Barton's registration should be restricted prior to hearing before the PCC.

[illegible]
www.gmc-uk.org

On 28 May 2002, Mrs Mackenzie (daughter of the late Gladys Richards) wrote to the GMC. She copied the letter to David Blunkett MP, your force, Nigel Waterson MP, Peter Viggers MP, the Police Complaints Authority, the CPS and David Parry of Treasury Counsel. She was concerned about the failures of the police investigation. As a result, your investigation was reopened. In July 2002, the then Commission for Healthcare Improvement published a report entitled "Gosport War Memorial Hospital Investigation into the Portsmouth Healthcare NHS Trust". The report did not name Dr Barton specifically, but referred to the criminal investigations and criticised the systems in place at the time.

On 30 July 2002, Mrs Mackenzie informed the GMC that the police were seeking advice from the CPS about the investigations and as a result were reconsidering the 5 cases.

The GMC and the police investigation

On 20 November 2002 Detective Inspector Niven and Detective Sergeant Kenny met Judith Christie of the GMC's solicitors, Field Fisher Waterhouse ("FFW"). Ms Christie was informed that a meeting was arranged between your force and the CPS on 28 November 2002. The result of that meeting was that the investigation should be continued and expanded. By letter dated 2 December 2002, FFW were asked to consider postponing the PCC hearing (which at that point was anticipated to take place in April 2003).

Accordingly the case was removed from the GMC's lists.

On 30 September 2003, you and DI Niven met with Linda Quinn of the GMC to discuss progress in the investigation. You reported that the view of the all the deaths of patients under Dr Barton's care at the hospital had suggested that the treatment of some 15 or 16 fell into the category of "negligence, cause of death unclear". At that point, you anticipated interviewing Dr Barton, once a second team of experts had reviewed these cases, which you believed would be January 2004. You also indicated that you were unable to provide full details of your investigation, as this could jeopardise further investigations and your proposed interview of Dr Barton.

On 2 October 2003, Linda Quinn wrote to you indicating that the GMC was considering referring Dr Barton's case yet again to the Interim Orders Committee and requesting that you supply the GMC with a detailed written summary of the evidence you had obtained, including any report prepared by the team of experts. You replied on 6 October 2003, confirming the content of your discussions with Linda Quinn on 30 September 2003 and stating: "*... our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegations such as those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton.*"

A Medical Screener of the GMC again considered the case with a view to referring Dr Barton to the Interim Orders Committee in November 2003. However, the Screener felt that as a result of the lack of new evidence, the IOC would come to the same decision as previously.

On 7 January 2004, Linda Quinn wrote to you asking for an update on progress. DI Niven replied on 28 January 2004, indicating that Hampshire Constabulary were unable to provide any further information at that point.

Linda Quinn wrote again on 6 February 2004 saying that the GMC had no further information about the case and that the GMC's inquiries were on hold pending conclusion of the police investigations.

Your investigation into Dr Barton

Throughout your investigation you have kindly kept us informed of the actions being taken by you and your colleagues. However, it seems that some two years after the investigation was recommenced, no decision has yet been reached in relation to bringing any charges against Dr Barton.

It would seem that further investigation is still required in relation to a number of matters before you are able to either bring charges or disclose any further information to the GMC.

The GMC's position

The General Medical Council, as a public authority, has a duty to bring matters concerning the fitness to practise of registered practitioners to a hearing within a reasonable time. Undue delay can seriously prejudice our function and may result in successful abuse of process applications.

I am very concerned that Dr Barton's GMC case has now been open for almost four years without any substantive progress.

Conclusion

The GMC is required to progress complaints against doctors, regardless of the circumstances, as expeditiously as possible. Such information as the GMC has received would suggest grave concerns about Dr Barton's fitness to practise. The current situation, in which the GMC is awaiting developments in the police investigation, without any indication when this may be concluded, is deeply unsatisfactory.

I should be very grateful if you could take the following steps:

a. indicate when you think it likely your investigations will be concluded and with what result; and

b. consider again whether there is any further information which you may be able to release that would allow the GMC to progress its own investigation.

In this respect, I would remind you that there is no principle of law which would require any GMC case to await the conclusion of any criminal proceedings against Dr Barton, though the GMC appreciates that in certain circumstances this may be desirable.

The GMC remains concerned that in the very troubling case, it is unable to take the steps that may be required to protect the public, as it is required to do by statute. Whilst we recognise the issues involved from the perspective of the police investigation, our view must be that, should you have information available to you that suggests any risk to public safety is posed by Dr Barton continuing to practise as a doctor, the protection of the public must be both your own and the GMC's primary interest and, as such, it is imperative that this is disclosed to the GMC at the earliest juncture.

I look forward to your early reply.

Yours sincerely

Code A

Peter Steel
Solicitor

Code A

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Police Headquarters
West Hill
Romsey Road
Winchester
Hampshire
S022 5DB

Our Ref. Op Rochester

Your Ref.

Tel. 0845 0454545
Fax. 02392 892608

21st April 2004

Ms L Quinn
General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Ms Quinn

Re: Operation Rochester - Investigation into Deaths at Gosport War Memorial Hospital

I write to inform you of a change in the management team on Operation Rochester. From Tuesday 20th April 2004, due to illness, DCI Nigel Niven will be temporarily leaving the enquiry. He will be replaced by DCI David Williams who will assume the role of Deputy Senior Investigating Officer until further notice.

David can be contacted through the incident room at Fareham Police Station on **Code A**

Yours Sincerely

Code A

SA Watts MSc, DPM, MCIM.
Detective Chief Superintendent

In reply please quote FPD/LQ/2000/2047

Please address your reply to
Conduct Case Presentation Section, FPD
Fax 020 7915 3696

16 March 2004

Mr Nigel Niven
Deputy SIO
Operation Rochester
Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Niven

Dr J Barton

You will recall that it was agreed at our meeting on 27 February 2004 that I would check the GMC files to see if there was any mention of a voluntary undertaking by Dr Barton.

There is no record of Dr Barton having made a voluntary undertaking to the GMC. However, it would appear that she did agree with the Isle of Wight, Portsmouth and South East Hampshire Health Authority in February 2002 that she would voluntarily stop prescribing opiates and benzodiazepines. By September 2002, when the Interim Orders Committee last considered Dr Barton's case, her legal team informed the IOC that the Health Authority had lifted the condition.

Yours sincerely

Code A

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate

Code A

Fax

To Nigel Niven, DSIO

Fax number Code A

From Linda Quinn

Direct Dial **Code A**

Direct fax

No. of pages (inclusive) 2 *Time* 17:00 *Date* 16 March 2004

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Please see attached letter.

TRANSMISSION VERIFICATION REPORT

TIME : 16/03/2004 17:03
NAME : GMC
FAX : Code A
TEL :

DATE,TIME	16/03 17:03
FAX NO./NAME	Code A
DURATION	00:00:38
PAGE(S)	00
RESULT	ERROR
MODE	STANDARD

Fax

To Nigel Niven, DSIO

Fax number Code A

From Linda Quinn

Direct Dial / Direct Fax **Code A**

No. of pages (inclusive) 2 Time 17:00 Date 16 March 2004

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please see attached letter.

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Operation Rochester
Fareham Police Station
Quay Street
Fareham
Hampshire, PO16 ONA

Tel. 0845 0454545
Fax. 023 80599838

Our Ref. Op Rochester

Your Ref.

11th March 2004

Ms L Quinn
General Medical Council
178 Great Portland Street
London
WIW 5JE

Dear Ms Quinn,

Re: Operation Rochester – Relocation.

I am writing to inform you of our relocation. From Monday the 15th of March 2004, the Operation Rochester team will be working from the incident rooms at Fareham Police Station. This relocation has provided the investigation team with additional office space to support the ongoing enquiry.

I have provided below our contact numbers.

Our direct dial number is Code A
Our fax number is Code A

The direct dial number will be connected to the answer phone when the office in unmanned.

If I can assist you in any way, please do not hesitate to contact me.

Code A

Nigel Niven
Deputy Senior Investigating Officer

In reply please quote FPD/LQ/2000/2047

Please address your reply to
Conduct Case Presentation Section, FPD
Fax 020 7915 3696

6 February 2004

Mr Nigel Niven
Deputy SIO
Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Niven

Dr J Barton

Thank you for your letter of 28 January 2004.

I note your comments regarding the second team of experts, and that it was never your intention for their analysis to have been undertaken by January 2004. You also refer to the minutes of our meeting in September 2003. While you and I both took a note, these notes were never agreed between us as formal minutes and we have not seen each other's notes. It is clear from what you say that I have misunderstood what Mr Watts was expecting to be complete by January 2004. It was my understanding, from what Mr Watts said, that the quality assurance check was to be undertaken in October, and that then a second team would be instructed in respect of certain cases, reporting not before January 2004, at which point the police might wish to interview Dr Barton. I now understand the penultimate paragraph of your letter of 28 January 2004 to be the correct and current position.

Please let me know at any time if you think that a meeting would be of assistance to either of our organisations. For our part, at present, apart from the update you have just supplied, we have no further information beyond that included in my letter of 7 January 2004 and our inquiries are on hold pending conclusion of the police investigations.

Yours sincerely

Code A

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate

Code A

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Tel. 0845 0454545
Fax. 023 80599838

Our Ref.

Your Ref. FDP/LQ/2000/2047

28th January 2004

Ms Quinn
Conduct Case Presentation Section
FPD
General Medical Council
178 Great Portland Street
London, W1W 5JE

Dear Ms Quinn

Re Gosport War Memorial Hospital – Operation Rochester

Thank you for you letter of the 7th January 2004, addressed to Mr Watts, the content of which I have noted. At the present time Mr Watts is on leave and I have been asked to reply to you on his behalf.

Within your letter you point out that, in essence, the position of the GMC has not changed since October 2003. Likewise, out of necessity, our position also remains fundamentally the same for the reason given in our letter of the 6th October 2003.

In respect of Professor Baker's report, you are correct to point out that reference was made to this document in the same letter. However, I am sure you will understand that distribution of this report is a matter entirely for the office of the Chief Medical Officer.

Having undertaken a process of quality assurance, we are about to commence the process of informing the relatives associated with Operation Rochester with the outcome of the initial analysis of our clinical team. This will be completed by mid February.

In your last paragraph you make reference to our second team of experts and an expectation of a report being ready in January 2004. It is unclear to me why you should think this to be the case. I have read the minutes taken in respect of our meeting held 30th September 2003 and our subsequent correspondence and can find no reference to such a report being

expected by January. It was never our position that we would have such an analysis completed by that time. That said, it is our intention to conduct such an analysis by a second team in respect of certain cases. We will, of course, continue to update you, to the extent we can, as to the progress of our investigation. Indeed, it might be useful to consider meeting in the near future should you think that it would be of some use.

If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Code A

Nigel Niven
Deputy SIO

In reply please quote FPD/LQ/2000/2047

Please address your reply to
Conduct Case Presentation Section, FPD
Fax 020 7915 3696

7 January 2004

Detective Chief Superintendent Steve Watts
Police Headquarters
Hampshire Constabulary
West Hill
Winchester
Hampshire
SO22 5DB

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Watts

Dr J A Barton

It is some time since we discussed the case of Dr Barton, and I am now writing to let you know the current position although in essence from our point of view it has not changed since October 2003.

Following receipt of your letter of 6 October 2003 I discussed the case with our Principal Legal Adviser and then submitted the information you gave me to the Medical Screener. The Screener determined that the case should not be referred back to the Interim Orders Committee (IOC) at the present time as there was no new evidence to put to the Committee.

As we discussed, any papers which are submitted to the IOC in respect of a doctor must be made available to that doctor. Therefore I am not able to reassure you that any material you might provide to the GMC in respect of Dr Barton would not be disclosed to her.

In your letter of 6 October 2003 you referred me to Professor Baker's report but this has not been made available to the GMC.

I am aware that your second team of experts was expected to report in January 2004 and I would be grateful to receive further information from you as and when you are in a position to disclose it.

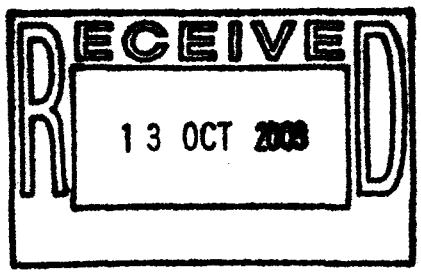
Yours sincerely

Code A

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate

Code A

HAMPSHIRE CONSTABULARY



Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

S Watts MSc DPM MIMgt
Detective Chief Superintendent
Head of CID

email: Code A

Your ref:

Our ref: SW/chm

6th October 2003

Ms L Quinn
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Ms Quinn

Re: **Gosport War Memorial Hospital - Operation Rochester**

Thank you for your letter dated 2 October 2003, following our meeting on 30 September 2003 regarding the above matter.

I note your comments, in particular the processes by which the GMC may consider the matter of registration.

The summary which we provided you in respect of our investigation, indicated that a team of clinical experts had examined hospital records in respect of 62 patients at Gosport War Memorial Hospital, under the care of Dr Barton. In a significant number of those cases, the experts take the view that there was negligent care and that the causation of death is unclear. As my colleague DI Niven and I explained, much further work needs to be done to validate and develop these very provisional findings. We took the view, however that the GMC and the relevant Strategic Health Authority should be appraised of this information.

As we explained to you, our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegation such those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to the public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton.

Our investigation has only considered cases up to 1998 and all relate to the treatment of patients at the Gosport War Memorial Hospital. All the cases of concern raise issues in respect of the use of opiates. My understanding at the present time is that Dr Barton is not allowed to work at the Gosport War Memorial Hospital, and is not authorized to prescribe opiates.

On the basis of the above, I think more assessment needs to be conducted to quantify and clarify the risk that Dr Barton continuing to practice currently presents to the public safety. I would emphasize that our investigation has only concerned itself with issues within the Gosport War Memorial Hospital and not in any other area of practice by any medical staff. You will be aware that Professor Richard Baker was tasked with conducting some analysis by the Chief Medical Officer. His remit would have been wider than ours and although I do not know the outcome of his research, I would imagine any conclusions he has reached might assist you in your deliberations.

It is probable that we will need to interview Dr Barton at length. The interview process is predicated upon a detailed strategy which will include a careful consideration of the information supplied to Dr Barton prior to interview. I note that your letter indicates that any information supplied to the GMC will in its totality be supplied to Dr Barton. Any uncontrolled disclosure to Dr Barton has the potential to detrimentally impact upon the investigation, and I therefore would be reluctant to disclose further information until the above issue of risk has been given thorough consideration.

If I were reassured that material would not be passed to Dr Barton or her representatives, I would be willing to consider, at a future time, providing a more detailed disclosure of information to the GMC. We would be more than happy to discuss with the GMC 'Screener' how we may best achieve the maximum disclosure without a detrimental impact upon the investigation.

Finally, in answer to your question, I can confirm that the patients that you name in the second page of your letter of 30 September were included in those reviewed by the team of clinical experts.

I look forward to hearing from you so that we may progress this matter together.

Yours sincerely

Code A

Steve Watts
Detective Chief Superintendent
Head of CID

In reply please quote FPD/LQ/2000/2047

Please address your reply to
Conduct Case Presentation Section, FPD
Fax 020 7915 3696

GENERAL MEDICAL COUNCIL

2 October 2003

Detective Chief Superintendent Steve Watts
Police Headquarters
Hampshire Constabulary
West Hill
Winchester
Hampshire
SO22 5DB

Dear Mr Watts

Dr J A Barton

I refer to our meeting on 30 September 2003 when you informed me of the stage reached in the Hampshire Constabulary's investigations in this case. I have now had an opportunity to discuss that information within the GMC.

In order for Dr Barton's case to be referred to the Interim Orders Committee (IOC), prima facie evidence is required which is cogent and credible and raises a question as to whether Dr Barton should have a restriction placed on her registration. This information would then be considered by a medical member of the GMC (the screener) with regard to a referral to the IOC. For example, if there is evidence that Dr Barton has been prescribing in an inappropriate and irresponsible manner, and the screener refers this to the IOC, it would be open to the IOC to place a condition on her registration restricting her prescribing. The Committee also has the power to suspend a doctor's registration.

The IOC may make an order when it determines that it is necessary for the protection of members of the public or is otherwise in the public interest or the interests of the doctor. As well as protection of the public, the public interest includes preserving public confidence in the medical profession and maintaining good standards of conduct and performance.

From the information that you provided on 30 September 2003, we consider that it is likely to be in the public interest that the matter is screened. However, we cannot give a final decision without further information.

Therefore could you please supply us with a detailed written summary of the evidence you have in this case to date, including any report prepared by the team of experts. The decision on referral of the information to IOC rests with the screener. If the information supplied is very brief, while it is likely that it would be passed to the screener, there is a possibility that the screener would not refer it to the IOC.

As we discussed on 30 September 2003, if Dr Barton's case is referred to the IOC, the documentation you provide will be disclosed to her and her legal representatives.

Could you please confirm whether the 62 individual cases scrutinised by your team of experts include the five which are already known to the GMC, as follows:

- Gladys Richards;
- Arthur Cunningham;
- Alice Wilkie;
- Robert Wilson;
- Eva Page.

We are grateful to you for keeping us informed of the progress of your investigation, and would ask that you continue to do so.

Please let me know if you require any further information from me before responding to this letter.

Yours sincerely

Code A

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate

Code A

Fax

To DCS Steve Watts, Hampshire Constabulary

Fax number Code A

From Linda Quinn

Direct Dial **Code A**

Direct fax

No. of pages (inclusive) 3 *Time* 11:55 *Date* 2 October 2003

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Watts

Dr J Barton

Please see attached letter.

Yours sincerely

Code A

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate

Code A

TRANSMISSION VERIFICATION REPORT

TIME : 02/10/2003 11:57
NAME : GMC
FAX : 020-7915-3696
TEL :

DATE,TIME	02/10 11:56
FAX NO./NAME	901962871130
DURATION	00:00:47
PAGE(S)	03
RESULT	OK
MODE	STANDARD ECM

Fax

To DCS Steve Watts, Hampshire Constabulary

Fax number Code A

From Linda Quinn

Direct Dial Code A

Direct fax

No. of pages (inclusive) 3 *Time* 11:55 *Date* 2 October 2003

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Watts

Dr. Barton

Please see attached letter.

Yours sincerely

Code A

Linda Quinn

[redacted]inda Quinn Code A

From: Linda Quinn Code A
Sent: 02 Oct 2003 08:45
To: Code A
Subject: Dr J Barton

Dear Mr Watts

I am about to write a formal letter to Hampshire Constabulary concerning this case. I will fax it to the number on your card unless you contact me in the meantime.

Could you please confirm who accompanied you on Tuesday 30 September 2003. The email I sent to him was returned as undeliverable.

Yours sincerely

Linda Quinn

Conduct Case Presentation Section
Fitness to Practise Directorate
[redacted] Code A

Your reference: FR/PR/31243/1/9516
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

15 January 2003

Mr Richard Follis
Alexander Harris
Cheriton House
51 Station Road
Solihull
West Midlands
B19 3RT

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letter of 15 January 2003.

This is an information case because we were first alerted to these matters by the Hampshire Constabulary in July 2000. This followed allegations made to them by the family of Gladys Richards.

We subsequently received correspondence from Mrs Jackson, Mr Page, Mr Wilson, Mrs Carby, Mr Farthing and Mrs McKenzie between April and June 2002. As advised in our letter dated 21 November 2001, we responded to each setting out our powers and procedures and that we were considering a case against Dr Barton in light of the information received from the Hampshire Constabulary.

As you know, we are still considering whether to include the case of Stanley Carby under No. 11 of the GMC PPC and POC (Procedure) Rules 1988; I should be grateful if you would let Mrs Carby know that, with Police inquiries ongoing and our investigations thereby stayed, we are unable to reach a decision on that question at the moment.

It may be of interest to note that, in complainant cases, we no longer fund complainants' choice of solicitors. I trust that clarifies the situation and that both you and your clients will continue to assist Messrs Field Fisher Waterhouse in the preparation of this case for hearing.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

c.c. Ms J Christie, Field Fisher Waterhouse

5a

Alexander Harris
solicitors

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

Our ref: RF/EP/31243/1/9516
Your ref: MK2000/2047
Please ask for: RICHARD FOLLIS
Direct dial: Code A

15 January 2003

ALSO BY FAX 020 7915 3641

GMC RECEIVED 15 JAN 2003 cash PO cheque T.C

Dear Mr Keegan

Re: Gosport War Memorial Hospital

I thank you for your letter of 18th December received shortly before the Christmas break.

I have to confess to some puzzlement as to how it is that this case proceeds as an information case, as opposed to a complainant case, given that the impetus has come, so far as I am aware, entirely from the complaining relatives.

Upon what information are the GMC proceeding?

When and why was the matter determined to be an information as opposed to a complainant case and by whom?

There are a series of complainants who by reason of your categorisation are deprived of the right to be represented by their solicitor of choice. Your further observations would be appreciated.

Yours sincerely

Code A

RICHARD FOLLIS
PARTNER
ALEXANDER HARRIS

Code A

Alexander Harris, Chorlton House, 61 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100 DX 720080 Solihull. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 926 6655 Facsimile: +44(0)161 926 6500 DX 18866 Altrincham 1.
1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.

Partners: David N Harris LL.B, Ann Alexander LL.B (Hons) M.B.A (Managing Partner), Lesley Herbertson M.A (Cantab), Nicola Castle LL.B (Hons) LL.M, Richard Follis LL.B (Hons), Jenny Kennedy, Lindsay Wise B.A (Hons), Grainne Barton LL.B (Hons), Richard Barr, Christian Beadnell LL.B (Hons), Aurlene Griffiths LL.B (Hons)
Consultants: Ruth Houghton LL.B (Hons), Prof. Danilo Gilmore B.A (Hons) J.D (Member of the Florida Bar)
Associates: Yee Fan Sit LL.B (Hons), Douglas I. Sligo LL.B (Hons), Savannah Read LL.B (Hons), Tim Annett LL.B (Hons), Kim Barrett B.A (Hons) LL.M, Jonathan Bath LL.B (Hons), Jo Markham LL.B (Hons), Chris Rhind LL.B (Hons), *Sue Taylor, *Debbie Murphy BGN, RM, Dip N, *Kirsty P Richards, *Kirsten Limb B.Sc (Hons). *(not a practising solicitor)

Alexander Harris is a franchised firm and a member of the Community Legal Service
Regulated by The Law Society

Your reference: FR/PR/31243/1/9516
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section
Fax 020 7915 3696

18 December 2002

Mr Richard Follis
Alexander Harris
Cherlton House
51 Station Road
Solihull
West Midlands B19 3RT

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letters of 12 and 13 December 2002.

I acknowledge receipt of Mr Farthing's authority and that your clients wish for you to deal with the preparation of the cases for hearing and the presentation/advocacy at the hearing.

This is an information case, as opposed to a complainant case; the relatives are not parties to the proceedings in the meaning given in paragraph 13 of Schedule 4 to the Medical Act 1983. We have, as you know, instructed Field Fisher Waterhouse to prepare this case for presentation for hearing by the Professional Conduct Committee and I trust that you and your clients will assist them with any further work necessary to prepare this matter.

We cannot, as you know, proceed to public inquiry while police investigations are ongoing. I am advised that those investigations are not likely to be concluded in the immediate future. It does not appear, therefore, that the PCC will be able to consider this case in the early part of next year, as we had hoped. We will, of course, advise you of developments at each stage, as appropriate.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

c.c. Ms J Christie, Field Fisher Waterhouse

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1058179

Alexander Harris
solicitors

General Medical Council
178 Great Portland Street
London
W1W 5JE

Our ref: RF/PR/31243/1/9516
Your ref: MK 2000/2047
Please ask for: RICHARD FOLLIS
Direct dial: Code A

13 December 2002

Dear Mr Keegan

Gosport War Memorial Hospital

Please find enclosed signed authority received from Charles Farthing confirming he wishes us to represent him in any GMC proceedings.

Please note our interest.

Yours sincerely

RICHARD FOLLIS
ALEXANDER HARRIS

Code A

Alexander Harris, Cheriton House, 51 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100
DX 720080 Solihull. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 925 5555 Facsimile: +44(0)161 925 5500 DX 19866 Altrincham 1.
1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.

6a

To: The General Medical Council

Your Reference

I, Charles Farthing, of Code A wish to be represented in my complaint to the GMC as to the treatment of Arthur Cunningham by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed... Code A

Dated ..... 30 NOV 02 .....

5a

Alexander Harris
solicitors

Mr M Keegan
General Medical Council
178 Great Portland Street
London W1W 5JE

Our ref: RF/EP/31243/1/9516
Your ref: MK 2000/2047
Please ask for: RICHARD FOLLIS
Direct dial: Code A

12 December 2002

Dear Mr Keegan

Re: Gosport War Memorial Hospital

I thank you for your letter of the 2nd December.

I assume that Messrs Field Fisher Waterhouse will be preparing the charge or charges.

Our clients wish us to deal with the preparation of the cases for hearing and the presentation/advocacy at the hearing.

Yours sincerely

Code A

RICHARD FOLLIS
PARTNER
ALEXANDER HARRIS

Code A

Alexander Harris, Cheriton House, 51 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100
DX 720080 Solihull. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 925 5555 Facsimile: +44(0)161 925 5500 DX 19866 Altrincham 1.
1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.

Your reference: FR/PR/31243/1/9516
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section
Fax 020 7915 3696

2 December 2002

Mr Richard Follis
Alexander Harris
Chenton House
51 Station Road
Solihull
West Midlands B19 3RT

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letter of 28 November 2002.

I note the authorities enclosed with your letter and that you are awaiting one further authority, presumably from Mr Farthing.

I will certainly keep you informed of developments. You should know that we have instructed Messrs Field Fisher Waterhouse in this matter and that I have copied your letter to their Ms Judith Christie.

I spoke to a number of your clients about two weeks ago and assured them that we would not proceed to public inquiry while police investigations were ongoing. We are in ongoing liaison with the police and await further information as to the likely course of their inquiries.

As you know, we decided that no further action by the GMC was warranted in relation to Mrs Bulbeck's complaint. We are considering inclusion of Mrs Carby's complaint under No. 11 of the GMC Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988. I will revert to you about this as soon as possible.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

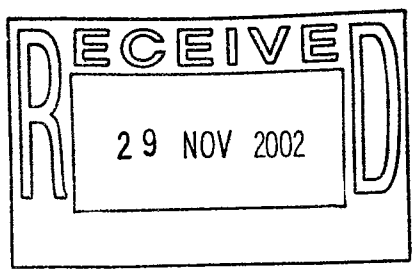
178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

5a

Alexander Harris
solicitors

Conduct Case Presentation Team
General Medical Council
178 Great Portland Street
London
W1W 5JE

Our ref: RF/PR/31243/1/9516
Your ref:
Please ask for: RICHARD FOLLIS
Direct dial: Code A



28 November 2002

Dear Mr Keegan

Gosport War Memorial Hospital

I thank you for Michael Hudspith's letter of 6 November.

Please find enclosed authorities from the following indicating that they wish us to represent them in GMC proceedings:-

1. Bernard Page
2. Iain Wilson
3. Rita Carby
4. Emily Yeats
5. Gillian McKenzie

Please note our interest and keep us updated as to progress. I am currently awaiting 1 further authority and shall forward this to you as soon as I receive it.

Yours sincerely

Code A

RICHARD FOLLIS
ALEXANDER HARRIS

Code A

Alexander Harris, Cheriton House, 51 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100 DX 720080 Solihull. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 925 5555 Facsimile: +44(0)161 925 5500 DX 19866 Altrincham 1.
1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.

5a

To: The General Medical Council

Your Reference

I, Rita Carby, of Code A wish to be represented in my complaint to the GMC as to the treatment of Stanley Carby by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed.. Code A

Dated ..13-11-02..

5a

To: The General Medical Council

Your Reference

I, Iain Wilson, of Code A wish to be represented in my complaint to the GMC as to the treatment of Robert Caldwell Wilson by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed Code A

Dated 13-11-02

5a

To: The General Medical Council

Your Reference

I, Bernard Page, of Code A wish to be represented in my complaint to the GMC as to the treatment of Eva Isabel Page by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed. Code A

Dated 13th November 2002

5a

To: The General Medical Council

Your Reference

I, Emily Yeats, of Code A wish to be represented in my complaint to the GMC as to the treatment of Alice Wilkie by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed Code A ...

Dated ...14.11.02.....

5a

To: The General Medical Council

Your Reference

I, Gillian McKenzie, of Code A wish to be represented in my complaint to the GMC as to the treatment of Gladys Richards by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed.. Code A

Dated 27.11.02

Your reference: RF/EP/31243/1/9516

Our reference: MH/misc

21 November 2002

Richard Follis
Alexander Harris Solicitors
Cherlton House
51 Station Road
Solihull
West Midlands B91 3RT

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Follis

Gosport War Memorial Hospital

I write further to your letter of 6 November 2002 and our recent telephone conversation.

You have enquired about complaints made to the GMC by the following clients of yours:

	Name of client	Name of relative
1.	Marjorie Bulbeck	Dulcie Middleton
2.	Emily Yeats	Alice Wilkie
3.	Bernard Page	Eva Page
4.	Ian Wilson	Robert Wilson
6.	Rita Carby	Stanley Carby
6.	Charles Farthing	Arthur Cunningham
7.	Gillian Mackenzie	Gladys Richards

On 12 September 2002 we wrote to clients 2, 3, 4, 6 and 7 to inform them that after considering information received from Hampshire Constabulary concerning the deaths at Gosport War Memorial Hospital of their respective relatives, the Council's Preliminary Proceedings Committee (PPC) decided that the reported actions of Dr Jane Barton be referred to the Professional Conduct Committee for inquiry into whether a charge of serious professional misconduct should be formulated against Dr Barton.

On 9 October 2002 we wrote to Mrs Carby to inform her that her complaint (which was not made available to the PPC due to its late arrival) would be passed to our

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

solicitors to assess and to establish whether it could or should be added to those matters already referred by the PPC.

On 7 November 2002 we wrote to Mrs Bulbeck to inform her that, after carefully considering her particular complaint, we had decided that no further action by the GMC was warranted.

I hope that you find this information helpful. Please note that those cases which are currently 'live' are being dealt with in our Conduct Case Presentation Team by my colleague Michael Keegan, tel: Code A

Yours sincerely

Code A

Michael Rudsplitt
Fitness to Practise Directorate

Code A

Alexander Harris
solicitors

Mr Michael Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE

Our ref: RF/EP/31243/1/9516
Your ref: 2002/0553
Please ask for: RICHARD FOLLIS
Direct dial: Code A

6 November 2002

Dear Mr Hudspith

Re: Gosport War Memorial Hospital

I thank you for your letter of 31st October 2002.

This firm acts for the individuals named in the attached Schedule and I would be grateful if you would please provide the information requested in my letter of 25th October in relation to each of these other complaints.

Yours sincerely

Code A

RICHARD FOLLIS
PARTNER
ALEXANDER HARRIS

Code A

Alexander Harris, Cheriton House, 51 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100
DX 720080 Solihull. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 925 5555 Facsimile: +44(0)161 925 5500 DX 19866 Altrincham 1.
1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.

SCHEDULE OF COMPLAINTS MADE TO GMC

1. Marjorie Bulbeck
2. Emily Yeats
3. Bernard Page
4. Iain Wilson
5. Rita Carby
6. Charles Farthing
7. Gillian McKenzie

5a

Alexander Harris
solicitors

FIRST CLASS
Michael Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE **ALSO BY FAX**

Our ref: RF/LS/31243/1/9516
Your ref:
Please ask for: RICHARD FOLLIS
Direct dial:

25 October 2002

Dear Mr Hudspith

Dr Jane Barton and Dr V Lord – Gosport War Memorial Hospital

We act fo[Code A] together with 18 other families who are concerned about events at Gosport War Memorial Hospital.

We understand that a number of complaints have been made to the General Medical Council confined so far as we are aware to the above two doctors. We further understand that certain individual complaints have so far as you are concerned been concluded although it appears from our instructions that others may be ongoing.

We would be grateful if you would please confirm whether there are any and if so what continuing proceedings or investigations on the part of the GMC in relation to either of the above two doctors or arising out of events generally at Gosport War Memorial Hospital.

We anticipate that we may well receive instructions to submit witness statements in support of complaints against Dr Barton and Dr Lord.

We have a meeting with our clients on Sunday 3rd November and would be grateful please for a response in advance of that meeting.

Yours faithfully

Code A

ALEXANDER HARRIS

Alexander Harris, Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 925 5555 Facsimile: +44(0)161 925 5500
DX 19866 Altrincham 1. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: 1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.
Cheriton House, 51 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100 DX 720080 Solihull.

Partners: David N Harris LL.B, Ann Alexander LL.B (Hons) M.B.A (Managing Partner), Lesley Herbertson M.A (Cantab), Nicola Castle LL.B (Hons) LLM, Richard Follis LL.B (Hons), Jenny Kennedy, Lindsay Wise B.A (Hons), Grainne Barton LL.B (Hons), Richard Barr, Christian Beadell LL.B (Hons), Auriana Griffiths LL.B (Hons)
Consultant: Prof. Daniel S Simons B.A (Hons) J.D (Member of the Florida Bar)
Associates: Yee Fon Sit LL.B (Hons), Douglas I. Silas LL.B (Hons), Susannah Read LL.B (Hons), Tim Annett LL.B (Hons), Kim Barrett B.A (Hons) LLM, Jonathan Betts LL.B (Hons), Jo Masters LL.B (Hons), *Sue Taylor, *Debbie Murphy RGN, RM, Dip N, *Kirsty R Richards, *Kirsten Limb B.Sc (Hons). *(not a practising solicitor)

Alexander Harris is a franchised firm and a member of the Community Legal Service
Regulated by The Law Society

Your reference: RF/LS/31243/1/9516

Our reference: 2002/0553

31 October 2002

By fax and post: 0161 925 5600

Richard Follis
Alexander Harris Solicitors
Ashley House
Ashley Road
Altrincham
Cheshire
WA14 2DW

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letter of 25 October 2002 concerning Gosport War Memorial Hospital. I returned from annual leave yesterday and apologise for the delay in responding.

The GMC's consideration of complaints about doctors prior to a public hearing before the Professional Conduct Committee is confidential to the individual complaint and doctor concerned. I am therefore unable to provide any comment about whether complaints made by people other than your client Code A may be on-going or closed.

As you will be aware, Mrs Reeves' complaint about Dr Barton was considered in June 2002 by both a medical and lay member of the Council. For the reasons outlined in our letter to Mrs Reeves of 11 June 2002, the members did not consider that her complaint raised any issue of serious professional misconduct or serious professional misconduct on the part of Dr Barton. Code A

You indicate in your letter that you may, in the future, submit witness statements to the GMC in support of further individual complaints. Should you do so I should be grateful if you would forward these for the attention of my colleague, Michael Keegan.

Yours sincerely

Code A

Michael Rudolph
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

MESSAGE CONFIRMATION

31/10/02 16:42

DATE	S.R-TIME	DISTANT STATION ID	MODE	PAGES	RESULT	
31/10	00'24"	901619255500	CALLING	01	OK	0000

31 02 16:41 NO.003 P01

Your reference: RF/LS/31243/1/9516

Our reference: 2002/0553

31 October 2002

By fax and post: 0161 925 5500

Richard Follis
Alexander Harris Solicitors
Ashley House
Ashley Road
Altrincham
Cheshire
WA14 2DW

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letter of 25 October 2002 concerning Gosport War Memorial Hospital. I returned from annual leave yesterday and apologise for the delay in responding.

Michael Keegan Code A

From: Michael Keegan Code A
Sent: 11 Oct 2002 12:17
To: 'Tanner Simon'
Subject: RE: Dr. B (your ref. MK/2000/2047)

Dear Simon

Thank you for that. I was aware that the CPS had been asked to advise. I have no word as to what that advice might be or when it will be given as yet, but I plan to meet with the Chief Superintendent James in the next week or so to discuss this matter.

I will keep you informed if anything substantially changes.

Regards

Michael Keegan
Conduct Case Presentation Section
Code A

-----Original Message-----
From: Tanner Simon Code A
Sent: 11 Oct 2002 10:25
To: Code A
Subject: Dr. B (your ref. MK/2000/2047)

Dear Michael

I am not sure if I mentioned to you in our telephone conversation that the police have referred the papers on this case back to the Crown Prosecution Service, for advice on whether further criminal prosecution should be considered.

This may have implications for your handling of the case referred to you.

Dr. Simon Tanner
Director of Public Health/Medical Director
Hampshire and Isle of Wight Health Authority

GENERAL MEDICAL COUNCIL

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

27 September, 2002

Ms Judith Christie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

RE: DR JANE ANN BARTON

Please find enclosed a letter dated 19 September 2002 with enclosures from Dr Simon Tanner at Hampshire and Isle of Wight Health Authority and my response of even date, both of which are self-explanatory.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

GENERAL MEDICAL COUNCIL

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

27 September, 2002

Dr Simon Tanner
Director of Public Health / Medical Director
Hampshire and Isle of Wight Health Authority
Oakley Road
Southampton
SO16 4GX

Dear Dr Tanner

I refer to your letter dated 19 September 2002 and our conversation of even date regarding Dr Barton.

I write to confirm that it has been decided not to refer Dr Barton back to the Interim Orders Committee again on the basis of the information included with your letter.

I have copied your letter and enclosures to solicitors instructed by the Council to prepare the case against Dr Barton at the Professional Conduct Committee.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Hampshire and Isle of Wight NHS
Health Authority

Oakley Road
Southampton
SO16 4GX

Tel: 023 8072 5400
Fax: 023 8072 5466
Direct Dial: Code A

www.hiow.nhs.uk
Code A

STRICTLY CONFIDENTIAL

19 September 2002

For the Attention of

Vanessa Carroll
Conduct Section
General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Vanessa

Dr Jane Barton

I enclose a file of correspondence, which was passed to the management of Fareham and Gosport Primary Care Trust by a member of staff on Monday 16th September 2002.

I believe that the contents of the file have relevance to the ongoing enquiries at the General Medical Council.

If you have any queries about this, please contact me on Code A

Yours sincerely

Code A

Dr Simon Tanner
Director of Public Health/Medical Director

Syringe driver & Pain control courses attended.

Pain control and use of the Syringe driver
(L. Foster) 1 hour, 10/12/90.

Pain Management.
(Steve King) 2 hours, 20/8/91.

ENB 941 (Drug review – pain control, Article review – Use & Abuse of Syringe drivers) 1991 – 1992.

Psychological Aspects of care & Pain control
(E. Cole – Jubilee House) 1 day, 13/2/92.

RCN Palliative care update,
Sept 1992.

Administration of drugs in the community & community hosps.
(Miranda Knight & Barbara Robinson) 1 day, 7/3/94.

Palliative care group 'At a loss',
QAH 1 day, 7/11/94.

RCN UPDATE – ukcc Guidelines on drug administration & record keeping
½ day, 22/2/96.

Effective pain control & management
QAH Elderly med. 11/2 hours 27/11/98.

Syringe drivers & drug compatibilities

(Rhonda Cooper) 2 hours, 11/5/99.
Update into use of Opiates
(DR Bee Wee) 1 hour, 26/8/99.

Palliative care issues including pain control
1 day, 12/5/00.

Summary of Meeting held at Redclyffe Annexe on 11.7.91

A meeting was arranged for the trained staff at Redclyffe Annexe following concern expressed by some staff at the prescribed treatment for 'Terminal Patients'

Present:- Mrs. Evans
Sister Goldsmith
Sister Hamblin
S/N Giffin
S/N Ryder
S/N Barrett
S/N Williams
S/N Donne
S/N Tubbritt
S/N Barrington
E/N Turnbull

The main area for concern was the use of Diamorphine on patients, all present appeared to accept its use for patients with severe pain, but the majority had some reservations that it was always used appropriately at Redclyffe.

The following concerns were expressed and discussed:-

1. Not all patients given diamorphine have pain.
2. No other forms of analgesia are considered, and the 'sliding scale' for analgesia is never used.
3. The drug regime is used indiscriminately, eachpatients individual needs are not considered, that oral and rectal treatment is never considered.
4. That patients deaths are sometimes hastened unnecessarily.
5. The use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients needs.
6. That too high a degree of unresponsiveness from the patients was sought at times.
7. That sedative drugs such as Thioridazine would sometimes be more appropriate.
8. That diamorphine was prescribed prior to such procedures such as catheterization* - where dizepam would be just as effective. (S ever as !)
9. That not all staffs views were considered before a decision was made to start patients on diamorphine - it was suggested that weekly 'case conference' sessions could be held to decide on patients complete care.
10. That other similar units did not use diamorphine as extensively.

Mrs. Evans acknowledged the staffs concern on this very emotive subject. She felt the staff had only the patients best interest at heart, but pointed out it was medical practice they were questioning that was not in her power to control. However, she felt that both Dr. Logan and Dr. Barton would consider staffs views so long as they were based on proven facts rather than unqualified statements. Mrs. Evans also pointed out that she was not an expert in this field and was not therefore qualified to condemn nor condone their statements, she did, however, ask them to consider the following in answer to statements made.

/...

1. That patients suffered distress from other symptons besides pain but also had the right to a peaceful and dignified death. That the majority of patients had complex problems.

2. If 'sliding scale' analgesia was appropriate in these circumstances, particularly when pain was not the primary cause for patient distress. That terminal care should not be confused with care of cancer patients.

3. The appropriateness of oral treatment at this time considering the patients deterioration and possibility of maintaining ability to swallow. The range of drugs available to cover all patients needs in drugs that can be given rectally together with patients ability to retain and absorb product.

4. It was acknowledged that excessive doses or prolonged treatment may be detrimental to patients health but was there any proven evidence to suggest that the small amounts prescribed at Redclyffe over a relatively short period did in fact harm the patients.

5. It could be suggested to Dr. Barton that drugs could be given via a butterfly for the first 24 hrs. to give trained staff the opportunityto regularise dose to suit patient.

6. That treatment sometimes needed regularising as patients condition changed -were staff contributing signs of patients deterioration to effects of drug? Few patients remained aware until the moment of death.

7. What was the evidence to suggest that thioridazine or any other similar drugs would be better.

8. Again, what was the objection to diamorphine being used in this way and how was diazepam better.

9. Mrs. Evans wholly supported any system which allowed all staff to contribute to patients care however, she could not see that weekly meetings were appropriate in this case where immediate action needed to be taken if any action was required at all.

10. What was the evidence to prove that these other units care of the dying was superior to ours,before any change could be taken on this premis it would need to be established that we would be raising our standards to theirs rather than dropping our standards to theirs.

It was evident that no one present had sufficient knowledge to answer these questions with authority, it was therefore decided that before any critisism was made on medical practice we needed to be able to answer the following questions.

- What effect does Diamorphine have on patients.

- Are all the symptons that are being attributed to Diamorphine in fact due to other drugs patients are recieving, or even their medical condition.

- Is it appropriate to give Diamorphine for other distressing symptons other than pain.

- Are there more suitable regimes that we could suggest.

/...

To try and find the answers to these questions Mrs. Evans would invite Kevin Short to talk to staff on drugs and ask Steve King from Charles Ward Q.A. if he would be prepared to contribute to discussion.

This would take time to arrange meanwhile staff were asked to talk to Dr. Barton if they had any reason for concern on treatment prescribed as she was willing to discuss any aspect of patient treatment with staff.

I hope I have included everyones views in this summary, as we will be using it to plan training needs, please let me know if there is any point I have omitted or you feel needs amending.

IE/LP
16.7.91

Confidential

REPORT OF A VISIT TO REDCLIFFE ANNEXE, GOSPORT WAR MEMORIAL HOSPITAL

AT 21.30 HOURS ON THURSDAY 31 OCTOBER 1991

BY

GERARDINE M WHITNEY, COMMUNITY TUTOR, CONTINUING EDUCATION

Purpose of Visit

The visit was in response to a request by Staff Nurse Anita Tubbritt to discuss the issue of anomalies in the administration of drugs.

Present

Staff Nurse Sylvia Giffin
Staff Nurse Anita Tubbritt
Enrolled Nurse Beverly Turnbull
Nursing Auxiliary Agnes Howard (Does not normally work at Redcliffe Annexe)
2 RGN's and 1 EN wished to but were unable to attend the meeting.

Background Information

The staff present presented the Summary of the Meeting held at Redcliffe Annexe on 11 July 1991 - appendix.

Problems Identified on 31 October 1991

1. Staff Nurse Giffin reported that a female patient who was capable of stating when she had pain was prescribed Diamorphine via syringe driver when she was in no obvious pain and had not complained of pain.

2. Staff Nurse Giffin reported that a male patient admitted from St Mary's General Hospital who was recovering from pneumonia, was eating, drinking and communicating, was prescribed 40 mg Diamorphine via a syringe driver together with Hyoscine, dose unknown, over 24 hours. The patient had no obvious signs of pain but had increased bronchial secretions.

3. Staff Nurse Tubbritt reported that on one occasion a syringe driver "ran out" before the prescribed time of 24 hours albeit that the rate of delivery was set at 50 mm per 24 hours.

4. The staff are concerned that Diamorphine is being prescribed indiscriminately without alternative analgesia, night sedation or tranquillisers being considered or prescribed.

5. Nurse Tubbritt reported that a female patient of 92 years awaiting discharge had i.m. 10 mg Diamorphine at 10.40 hours on 20.9.91. and a further i.m. 10 mg Diamorphine at 13.00 hours on 20.9.91. administered for either a manual evacuation of faeces or an enema.

6. There are a number of other incidents which are causing the staff concern but for the purposes of this report are too many to mention. The staff are willing to discuss these incidents.

7. It was reported by Staff Nurse Tubbritt that:

a) 42 ampoules of Diamorphine 10 mg were used between 20 April 1991 - 15 October 1991.

b) 57 ampoules of Diamorphine 30 mg were used between 15 April 1991 - 15 October 1991 (24 of the 57 ampoules of Diamorphine 30 mg were administered to one patient, who had no obvious pain, between 9 September 1991 and the 21 September 1991).

c) 8 ampoules of Diamorphine 100 mg were used between 15 April 1991 - 21 September 1991 (4 of the 8 ampoules of Diamorphine 100 mg were administered to the patient identified in 7b above, between 19 September 1991 and the 21 September 1991).

Note - This patient had previously been prescribed Oramorph 10 mg in 5 ml oral solution which was administered regularly commencing on 2 July 1991.

The staff cannot understand why the patient was prescribed Oramorph and Diamorphine.

When the staff questioned the prescription with Sister they were informed that the patient had pain. The staff recalled having asked the patient on numerous occasions if he had pain, his normal reply was no.

Conclusion

1. The staff are concerned that Diamorphine is being used indiscriminately even though they reported their concerns to their manager on 11 July 1991 (appendix).

2. The staff are concerned that non opioids, or weak opioids are not being considered prior to the use of Diamorphine.

3. The staff have had some training, arranged by the Hospital Manager, namely:

- The syringe driver and pain control
- Pain control

4. Staff Nurse Tubritt wrote to Evans the producers of Diamorphine and received literature and a video - Making Pain Management More Effective.

5. Staff Tubbritt is undertaking a literature on Pain and Pain Control.

Signed: Code A ..... Time: 23.35 hours

G M Whitney Code A
Community Tutor, Continuing Education

Date: 31 October 1991

PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

1·11·91.

Anita,

Sam meeting Sue Frost this pm. for her to check the Report. Will keep you informed,

Code A

Northern Parade Clinic
Doyle Avenue
Hilsea
Portsmouth
PO2 9NF

Tel: Portsmouth (0705) 662378

With Compliments

PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

COMMUNITY HEALTH CARE SERVICES

PORTSMOUTH CITY DIVISIONAL HEADQUARTERS
NORTHERN PARADE CLINIC
DOYLE AVENUE
PORTSMOUTH
PO2 9NF

Portsmouth (0705) 662378

Our ref: GMW/PSE

Your ref:

Please ask for.....

4 November 1991

Mrs. Anita Tubbritt

Code A

Dear Anita

Report of a Visit to Redclyffe Annexe, 31.10.91

Herewith a copy of the above named report. I have given copies of the report to:

Mrs. Susan Frost, Principal Solent School of Health Studies, QAH.

Mr. W. Hooper, General Manager (West) Gosport War Memorial Hospital.

Mrs. I. Evans, Patient Care Manager, Gosport War Memorial Hospital.

Those who were present at the meeting.

I also wish to assure you of my support and help in this matter. Please do not hesitate to contact either Sue Frost or myself if you require any guidance.

Yours sincerely

Code A

Gerardine M. Whitney
Community Tutor, Continuing Education.

ENC.

PORTSMOUTH AND SOUTH EAST
HAMPSHIRE HEALTH AUTHORITY

COMMUNITY HEALTH SERVICES AND SMALL HOSPITALS UNIT

GOSPORT WAR MEMORIAL HOSPIT.
BURY ROAD,
GOSPORT,
HANTS. PO12 3PW
Gosport 524611 Ext. .....

Our ref: Your ref:

Dear S.N Tubbritt.

Thank you for your letter dated 31.10.91 informing me of the meeting that took place on 31.10.91 with Gerine Whitney at Redclyffe Annexe re the use of Diamorphine at Redclyffe Annexe.

May I take this opportunity to once more state that I am happy to discuss any areas of concern that staff may have, in fact I would welcome open discussion. [redacted] as I feel the only alternative is disruptive criticism which achieves nothing positive and leaves staff feeling frustrated

Yours Sincerely.

Code A

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

MEMORANDUM

FROM: Mrs. I. Evans
Patient Care Manager
Gosport War Memorial Hospital

TO: See Distribution

Your Ref.

My Ref. IE/LP

7th November 1991

It has been brought to my attention that some members of the staff still have concerns over the appropriatness of the prescribing of Diamorphine to certain patients at Redclyffe Annexe.

I have discussed this matter with Dr. Logan and Dr. Barton who like myself are concerned about these allegations. To establish if there is any justification to review practice we have agreed to look at all individual cases staff have or have had any concerns over and then meet with all staff to discuss findings.

I am therefore writing to all the trained staff asking for the names of any patients that they feel Diamorphine (or any other drug) has been prescribed inappropriately.

To ensure everyones views are considered I would appreciate a reply from every member of staff even if it is purely to state they have no concerns, by 21st November.

I am relying on your full co-operation and hope on this occasion everyone will be open and honest over this issue so we are able to address everyones concerns and hopefully resolve this issue in a constructive and professional manner.

Code A

I. Evans

Distribution

Every trained member of Staff at Redclyffe Annexe

copy to: Night Sister
Dr. Logan
Dr. Barton
Mr. Hooper

visited MRS Evans to-day 27/11/91 9.30 am

WS11 504

P.P.

WESSEX REGIONAL OFFICE

General Secretary:
Christine Hancock
BSc(Econ) RGN

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Countess of Snowdon

8 Southgate Street
Winchester SO23 9EF
Telephone 0962 868332
Fax 0962 855819

SB/FFO

CWJHM Code A
(K. Murray)

22 November 1991

ROYAL COLLEGE OF NURSING

Mrs I Evans
Patient Care Manager
Gosport War Memorial Hospital
Bury Road
Gosport
Hants
PO12 3PW

Dear Mrs Evans,

I refer to your memorandum to staff at Redclyffe Annexe dated 7th November 1991 and Keith Murray's letter to you dated 14th November 1991. I believe it is important that I reinforce the RCN's position as indicated to you in Mr Murray's letter.

This office was aware of the concerns that had been expressed by staff earlier this year and other discussions that had taken place with yourself as the Manager. It had been understood that the concerns raised would be addressed and the RCN had anticipated that clear guidance/policy would be promulgated as a result of the very serious professional concerns Nursing Staff were expressing.

It is now a matter of serious concern that these complaints were not acted upon in the way that had been anticipated and that Management are, some months after those discussions now seeking formal allegations. I would reinforce Mr Murray's position that this is not acceptable and the RCN is not prepared to be drawn into what could emerge as a vindictive witch hunt that would divide Nursing Staff, Medical Staff and Management. The complaints were adequately reported to Management earlier this year and you have received further evidence by way of Gerrie Whitney's report dated 31 October 1991. We now expect a clear policy to be agreed as a matter of urgency.

If it is not possible for Management to achieve this, the RCN will need to seek further instructions from its membership to pursue this matter through the grievance procedure on the basis that Management have failed to manage this situation properly.

Yours sincerely

ANNIVERSARY RCN · 1916 75 1991 · 1916 · 1991

Steve Barnes
RCN Officer - Wessex

C.C: Keith Murray

Headquarters:
20 Cavendish Square
London W1M 0AB
Telephone 071-409 3333
Fax 071-355 1379

General Secretary:
Christine Hancock
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the Queen Mother
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the Princess Margaret
Countess of Snowdon

20 Cavendish Square
London W1M 0AB
Telephone 071 409 3333
Fax 071 355 1379

2nd December 1991

Anita Tubbritt,

Code A

ROYAL COLLEGE OF NURSING

Dear Anita,

Thank you for giving me the opportunity to speak to you over what I know is a very emotive and difficult subject.

As agreed at our meeting I have written to Chris West, District General Manager and enclosed a personal copy, I will keep you informed of any information as I receive it. I have spoken to Gerrie and also sent her a copy.

I would like to take the opportunity to reinforce the fact that you have the support of the RCN in this subject and if I can be of any more help please don't hestiate in contacting me.

With best wishes.

Regards,

Code A

Keith Murray

Branch Convenor

Code A

enc.

75 ANNIVERSARY RCN · 1916 · 1991 · 1916 · 1991

General Secretary:
Christine Hancock
BSc(Econ) RGN

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the Princess Margaret
Countess of Snowdon

20 Cavendish Square
London W1M 0AB
Telephone 071 409 3333
Fax 071 355 1379

[redacted] December 1991

Mr C West,
District General Manager,
District Offices,
St. Mary's Hospital,
Milton,
Portsmouth,
Hants. PO3 6AD

Dear Chris,

I am seeking your advice on how best to resolve a problem which was brought to my attention in April 1991 but apparently has been present for the last 2 years.

[redacted] was contacted by a staff nurse who is currently employed on night duty in Redclyffe Annexe, her concern was that patients within Redclyffe were being prescribed Diamorphine who she felt did not always require it, the outcome being that the patient died. The drug was always being administered via 'syringe drivers'. It is fair to say that this member of staff was speaking on behalf of a group of her colleagues.

On my advice the staff nurse wrote to Isobel Evans, Patient Care Manager putting forward her requirements under the UKCC Code of Professional Conduct. Following this I had a meeting with Isobel Evans Patient Care Manager on the 26th April 1991, the outcome of this was that a 'policy' would be produced to specifically address the prescribing and administration of controlled drugs within Redclyffe. In addition a meeting would be held with the staff and Isobel where they could voice their concerns, this meeting took place on the 11th July 1991 and the minutes circulated, as these give a clear outline of the concerns of the staff I have enclosed a copy for your perusal.

Following the aforesaid meeting two study days on 'Pain Control' were arranged, as you will see from the minutes relating to the meeting of the 11th July 1991 some of the concerns voiced by the staff were that diamorphine was being prescribed for patients who were not in pain. These study days did temporarily alleviate the worries of the staff.

Regrettably the concerns of the staff have once again returned, one of the staff nurses who is currently on an ENB course was talking about this subject to Gerrie Whitney, Community Tutor, Continuing Education. Gerrie visited Redclyffe on the 31st October 1991 and subsequently wrote a report. Copies of her report were circulated to Isobel, Bill Hooper and Sue Frost, as I feel it is pertinent I have obtained Gerrie's permission to enclose a copy.

After receiving this report Isobel responded by sending a 'memo' (copy enclosed) to the trained staff at Redclyffe. As the 'concerns' had now apparently become "allegations" I wrote to Isobel voicing my concern on this point, also that she had to date not produced the policy to which we had agreed in April 1991. I also informed her that it was my view that unless I heard to the contrary a grievance would have to be lodged. To date Isobel has not responded.

I feel the staff have acted professionally and with remarkable restraint considering that it is fair to say that since highlighting their concerns there has been a certain amount of ostracization. After talking to the staff and thinking it through I now feel that a grievance may not completely resolve this issue. I have been told that it is only a small group of night staff who are 'making waves', this could be true as a majority of the day staff have left over the period of 2 years that this situation has been present, whether this was a reason for their leaving I am unsure.

I have various concerns, for the patients and subsequently their relatives, the staff in that they are working in this environment but also that this could be leaked to the media. While none of the staff or myself have any desire whatsoever to use this means there is serious concern from both myself and the staff that someone could actually leak this and I hope you know my feelings about the media and using it as a means of resolving problems. On this basis alone I hope you agree with me in that we have to address this issue urgently.

As I stated at the beginning I am seeking your advice on what I think you will now feel is a difficult problem. I must stress that none of the staff have shown any malice in what they have said and that their only concern is for the patient.

Your comments/advice would be greatly appreciated.

Yours sincerely,

Keith Murray

Branch Convenor

Code A

General Secretary:
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20 Cavendish Square
London W1M 0AB
Telephone 071 409 3333
Fax 071 355 1379

ROYAL COLLEGE OF NURSING

2nd December 1991

Beverley Turnbull,

Code A

Dear Beverley,

Thank you for giving me the opportunity to speak to you over what I know is a very emotive and difficult subject.

As agreed at our meeting I have written to Chris West, District General Manager and enclosed a personal copy, I will keep you informed of any information as I receive it. I have spoken to Gerrie and also sent her a copy.

I would like to take the opportunity to reinforce the fact that you have the support of the RCN in this subject and if I can be of any more help please don't hestiate in contacting me.

With best wishes.

Regards,

Code A

Keith Murray

Branch Convenor

Code A

enc.

ANNIVERSARY RCN · 1916 · 75 · 1991 · 1916

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

MEMORANDUM

FROM: Mrs. I. Evans
Patient Care Manager
Gosport War Memorial Hospital

TO: All trained Staff at Redclyffe
copy to: Night Sisters
Mr. W. Hooper
Dr. Logan
Dr. Barton

Your Ref.

My Ref. IE/LP

5th December 1991

Due to the lack of response to my memo of the 7th November Dr. Logan will be unable to comment on specific cases, however, we have arranged a meeting for all members of staff at Redclyffe who have concerns on the prescribing of Diamorphine on Tuesday 17th December at 2 p.m. to discuss the subject in general terms.

It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have so I hope everyone will take the opportunity to attend and help resolve this issue.

Code A

I. Evans

General Secretary:
Christine Hancock
BSc(Econ) RGN

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Countess of Snowdon

20 Cavendish Square
London W1M 0AB
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Fax 071 355 1379

10th December 1991

Mrs I Evans,
Patient Care Manager,
Gosport War Memorial Hospital,
Bury Road,
Gosport,
Hants.,
PO12 3PW

Dear Mrs Evans,

I am receipt of a copy of the letter dated 5th December 1991 you have sent to Mr S Barnes RCN Officer.

As far as I am aware it is not the use of syringe drivers that is the cause of concern and I refer you to the minutes of the meeting that you produced after your meeting of the 11th July 1991 with the staff.

I further note that you are holding a further meeting with the staff "to once again re-address this problem". As you are fully aware of the issues which are causing the concerns from the staff the purpose of this meeting has to be doubtful. I refer you to the agreement following our meeting on the 26th April 1991 which was that a policy would be drawn up to address the issue of the concerns voiced by the staff. This has failed to materialise.

I would reaffirm the position as stated in my letter 14th November 1991 and reiterated by Mr Barnes in his letter dated 22nd November 1991 the serious concern in the lack of a positive response to what is considered a perfectly reasonable request from staff who have acted both professionally and with remarkable restraint. Furthermore that some seven months have passed since this issue was first drawn to your attention. Unless I receive a response in that a policy will be drawn up which clearly addresses all the concerns is received from the staff following your meeting I will be raising a grievance on behalf of the staff.

Yours sincerely,

Keith Murray

Branch Convenor

Code A

cc Mr S Barnes, RCN Officer - Wessex

General Secretary:
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BSc(Econ) RGN

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London W1M 0AB
Telephone 071 409 3333
Fax 071 355 1379

10th December 1991

Anita Tubbritt,

Code A

ROYAL COLLEGE OF NURSING

Dear Anita,

I enclose a copy of the letter I have sent Mrs Evans.

I think I have made it quite clear that unless you receive confirmation at your meeting that a policy will be drawn up which addresses all the concerns that you first brought to Mrs Evans attention back in July then a grievance will be lodged. If I hear from Chris West in the meantime I will naturally let you know immediately.

I hope my letter brings a positive response, the important thing at your meeting to remember is that you are the ones acting professionally and correctly, try to be assertive and don't be fobbed off. I will be thinking of you.

With best wishes.

Yours sincerely,

Code A

Keith Murray

Branch Convenor

Code A

75 ANNIVERSARY RCN 1916 1991 1916 1991

General Secretary:
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10th December 1991

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Bury Road,
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cc Mr S Barnes, RCN Officer - Wessex

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10th December 1991

Beverley Turnbull,

Code A

ROYAL COLLEGE OF NURSING

Dear Beverley,

I enclose a copy of the letter I have sent Mrs Evans.

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With best wishes.

Yours sincerely,

Code A

Keith Murray

Branch Convenor

Code A

75 ANNIVERSARY RCN · 1916 · 1991 · 1916

Notes of a Meeting held on Tuesday 17th December 1991 at Redclyffe Annexe for staff who had concerns related to the use of Diamorphine within the unit.

PRESENT

Mrs. Evans, Patient Care Manager
Dr. Logan, Consultant, Geriatrician
Dr. Barton, Clinical Assistant
Sister Hamblin
S.N. Donne
S.N. Barrett
S.N. Giffin
S.N. Tubbritt
E.N. Wigfall
E.N. Turnbull

All trained staff were invited to the meeting if they were concerned with this issue, no apologies were received.

Mrs. Evans opened the meeting by thanking everyone for coming and highlighting the following:-

1. A staff meeting was held on 11th July 1991 to establish all staff's concerns re: the use of Diamorphine for terminal patients at Redclyffe Annexe.

2. A second meeting was held on 20th August where Steve King, Nurse Manager, Elderly Services Q.A.H. and Dr. Logan spoke to the staff on drug control of symptoms. The aim of this meeting was to allay staff's fears by explaining the reasons for prescribing. As no one challenged any statements at this meeting or raised any queries, it was assumed the problem had been resolved and no further action was planned.

   A recent report from a meeting held with Gerrie Whitney, Community Tutor, indicated some staff still had concerns, so a further meeting was planned for 17th December 1991.

3. Staff were invited to give details of cases they had been concerned over but no information was received; it was therefore decided to talk to staff on the general issue of symptom control and all trained staff would be invited to attend.

4. This issue had put a great deal of stress on everyone particularly the medical staff, it has the potential of being detrimental to patient care and relative's peace of mind and could undermine the good work being done in the unit if allowed to get out of hand. Everyone was therefore urged to take part in discussions and help reach an agreement on how to proceed in future.

5. Staff were asked to bear in mind that the subject was both sensitive and emotive and to make their comments as objective as possible.

/...

As Mrs. Evans had presented staff's concerns she stated the problem as she saw it and invited staff to comment if they did not agree with her interpretation:-

1. We have an increasing number of patients requiring terminal care.

2. Everyone agrees that our main aim with these patients is to relieve their symptoms and allow them a peaceful and dignified death.

3. The prescribing of Diamorphine to patients with easily recognised severe pain has not been questioned.

4. What is questioned is the appropriateness of prescribing diamorphine for other symptoms or less obvious pain.

5. No one was questioning the amounts of Diamorphine or suggesting that doses were inappropriate.

   All present agreed with these statements, no other comments were asked to be considered.

Mrs. Evans then reminded staff that at the July meeting it had been agreed that she neither had the authority or knowledge to write a policy on the prescribing of drugs, but she would be happy to talk to staff at the end of the meeting if any member of staff had concerns relating to the administration of drugs which was not amply covered by the District Drug Manual or U.K.C.C. Administration of Medicines. Dr. Logan then spoke to the staff at length on symptom control covering the following points:-

a. First priority was to establish cause of symptom and remove cause if possible.

b. Where appropriate the 'sliding scale' of analgesics should be used.

c. Oral medication should be used were possible and when effective (this raised the issue of the availability of Hyoscine as an oral preparation).

d. The aim of opiate usage was to produce comfort and tranquility at the smallest necessary dose - an unreceptive patient is not the prime objective.

e. The limited range of suitable drugs available if normal range of analgesics not effective.

f. That Diamorphine had added benefits of producing a feeling of well being in the patient.

g. The difficulty of accurately assessing levels of discomfort with patients who were not able to express themselves fully or who had multiple medical problems. The decision to prescribe for these patients had therefore to be made on professional judgement based on knowledge of patients condition, to enable patient to be nursed comfortably.

h. It was not acceptable for patients who are deteriorating terminally, and require 2 hrly turning, to have pain or distress during this process. They require analgesia even if they are content between these times.

/...

Following general discussion and answering of staff questions Dr. Logan stated he would be willing to speak to any member of staff who still had concerns over prescribed treatment, after speaking to Dr. Barton or Sister Hamblin. Comments raised during discussion were:-

(a) All staff had a great respect for Dr. Barton and did not question her professional judgement.

(b) The night staff present did not feel that their opinions of patients condition were considered before prescribing of Diamorphine.

(c) That patients were not always comfortable during the day even if they had slept during the night.

(d) There appeared to be a lack of communication causing some of the problem.

(e) Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms.

All staff agreed that if they had concerns in future related to the prescribing of drugs they would approach Dr. Barton or Sister Hamblin in the first instance for explanation, following which if they were still concerned they could speak to Dr. Logan.

Mrs. Evans stated she would also be happy for staff to talk to her if they had any problems they wanted advice on.

With no further points raised, Dr. Barton, Dr. Logan, Sister Hamblin and S.N. Barrett left the meeting to commence Ward rounds.

Mrs. Evans spoke to the remaining nursing staff.

Staff were asked if they felt there was any need for a policy relating to nursing practice on this issue. No one present felt this was appropriate. Mrs. Evans stated she was concerned over the manner in which these concerns had been raised as it had made people feel very threatened and defensive and stressed the need to present concerns in the agreed manner in future. She agreed with staff that there did seem to be a communication problem within the unit, particularly between day and night staff which had possibly been made worse by recent events. Mrs. Evans had already met with both the Day and Night Sisters in an attempt to identify problem and she advised staff to go ahead with planned staff meetings and offered to present staff's views from both Day and Night staff if they felt this would be useful. Mrs. Evans spoke to Sister Hamblin and S.N. Barrett the following morning to ask them to organise day staffs views and ask them to make every effort to ensure patients assessments were both objective and clearly recorded in nursing records.

Mrs. Evans would arrange a further meeting with both Night Sisters and Sister Hamblin following the staff meeting to ensure problems have been resolved with information handover from Day to Night Staff and vice versa.

General Secretary:
Christine Hancock
BSc(Econ) RGN

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20 Cavendish Square
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Telephone 071 409 3333
Fax 071 355 1379

11th January 1992

ROYAL COLLEGE OF NURSING

Mrs A Tubbritt,

Code A

Dear Anita,

I have now heard from Chris West District General Manager, in his letter Chris has passed the situation onto Max Millett Unit General Manager. I was at a meeting with Tony Horne General Manager, Community Unit who informed me that he had already spoken to Bill Hooper about the concerns that I had put in my letter to Chris West, Tony will be getting back to me in due course. I hope this is clear!

I know that after your last meeting with Mrs Evans your concerns may be eleviated, I still feel that the underlying problem is still there. I therefore hope that you agree with allowing this to run the course.

With best wishes for 1992.

Yours sincerely,

Code A

Keith Murray

Branch Convenor

Code A

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11th January 1992

ROYAL COLLEGE OF NURSING

Mrs Beverley Turnbull,

Code A

Dear Beverley,

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With best wishes for 1992.

Yours sincerely,

Code A

Keith Murray

Branch Convenor

Code A

Your reference:
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section
Fax 020 7915 3696

19 September, 2002

Dr Peter Old
Acting Chief Executive
Hampshire and Isle of Wight
Practitioner & Patient Services Agency
Cottbury House
Friarsgate
Winchester
Hampshire SO23 8EE

Dear Dr Old

I wrote to you on 11 July to inform you that allegations made against Dr Barton, who is contracted to your Health Authority, were to be considered by the Council's Preliminary Proceedings Committee.

As you are no doubt already aware, the Committee considered the matter at their meeting on 29 August 2002, following which they decided that the allegations, if proved, would amount to serious professional misconduct, and have therefore referred the matter to the Professional Conduct Committee. Further investigations will now be undertaken, and once these are complete, a hearing date will be fixed. We will notify of this date closer to the time.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

GENERAL MEDICAL COUNCIL

Your reference
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

16 September, 2002

Ms Julie Miller
Commission for Health Improvement
103-105 Bunhill Row
London EC1Y 8TG

Dear Ms Miller

I am writing to inform you, in confidence, that the Council's Preliminary Proceedings Committee have considered the information provided by the Hampshire Constabulary about Dr Barton. They have decided that a charge should be formulated against Dr Barton on the basis of the information, and that an inquiry into the charge should be held by the Council's Professional Conduct Committee.

No date has yet been fixed for the hearing of Dr Barton's case. It may well be necessary for a member of the GMC's solicitors to contact you in the near future in connection with the preparation of the case, and I should be grateful for your assistance.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Code A

13 September 2002.

Mr Michael Keegan
Conduct Case Presentation Section.
General Medical Council.
178 Great Portland Street.
London. W1W 5JE.

Dear Mr. Keegan.

Re: MK/2000/2047. Dr Jane Barton.

Please accept this as written confirmation that all necessary correspondence regarding the above should be sent to my daughter Miss Emily Heads. Her address is as follows:-

Code A

Due to my work commitments and the stress this situation has caused me, my daughter has agreed to step in. However, my daughter has my full support and co-operation in this matter.

Yours sincerely.

Code A

GENERAL MEDICAL COUNCIL
protecting patients, guiding doctors

Your reference
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

12 September, 2002

Ms G M MacKenzie

Code A

Dear Ms McKenzie

I am writing to inform you, in confidence, that the Council's Preliminary Proceedings Committee have considered the information provided by the Hampshire Constabulary about Dr Barton. They have decided that a charge should be formulated against Dr Barton on the basis of the information, and that an inquiry into the charge should be held by the Council's Professional Conduct Committee.

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Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

GENERAL MEDICAL COUNCIL

protecting patients, guiding doctors

Your reference

In reply please quote MK/2000/2047

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Fax 020 7915 3696

12 September, 2002

Mr S Page

Code A

Dear Mr Page

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Yours sincerely

Code A

Michael Keegan Code A
Conduct Case Presentation Section

Code A

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email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

GENERAL MEDICAL COUNCIL
protecting patients, guiding doctors

Your reference
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FRD
Fax 020 7915 3696

12 September, 2002

Mr I Wilson

Code A

Dear Mr Wilson

I am writing to inform you, in confidence, that the Council's Preliminary Proceedings Committee have considered the information provided by the Hampshire Constabulary about Dr Barton. They have decided that a charge should be formulated against Dr Barton on the basis of the information, and that an inquiry into the charge should be held by the Council's Professional Conduct Committee.

No date has yet been fixed for the hearing of Dr Barton's case. It may well be necessary for a member of the GMC's solicitors to contact you in the near future in connection with the preparation of the case, and I should be grateful for your assistance.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

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Your reference
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

12 September, 2002

Mrs M Jackson

Code A

Dear Mrs Jackson

I am willing to inform you, in confidence, that the Council's Preliminary Proceedings Committee have considered the information provided by the Hampshire Constabulary about Dr Barton. They have decided that a charge should be formulated against Dr Barton on the basis of the information, and that an inquiry into the charge should be held by the Council's Professional Conduct Committee.

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Please address your reply to Conduct Case Presentation Section, FRD
Fax 020 7915 3696

12 September, 2002

Mr C R S Farthing

Code A

Dear Mr Farthing

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No date has yet been fixed for the hearing of Dr Barton's case. It may well be necessary for a member of the GMC's solicitors to contact you in the near future in connection with the preparation of the case, and I should be grateful for your assistance.

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Code A

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email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your reference
In reply please quote

Chief supt/JJ/DM
MK/2000/2047

GENERAL MEDICAL COUNCIL
protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

12 September, 2002

C.I. J James
Hampshire Constabulary
Police Headquarters
West Hill
Romsey Road
Winchester
Hampshire
SO22 5DB

Dear C.I. James

I am writing to inform you, in confidence, that the Council's Preliminary Proceedings Committee have considered the information you provided about Dr Barton. They have decided that a charge should be formulated against Dr Barton on the basis of the information, and that an inquiry into the charge should be held by the Council's Professional Conduct Committee.

No date has yet been fixed for the hearing of Dr Barton's case. It may well be necessary for a member of the GMC's solicitors to contact you in the near future in connection with the preparation of the case, and I should be grateful for your assistance.

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Conduct Case Presentation Section

Code A

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email gmc@gmc-uk.org www.gmc-uk.org
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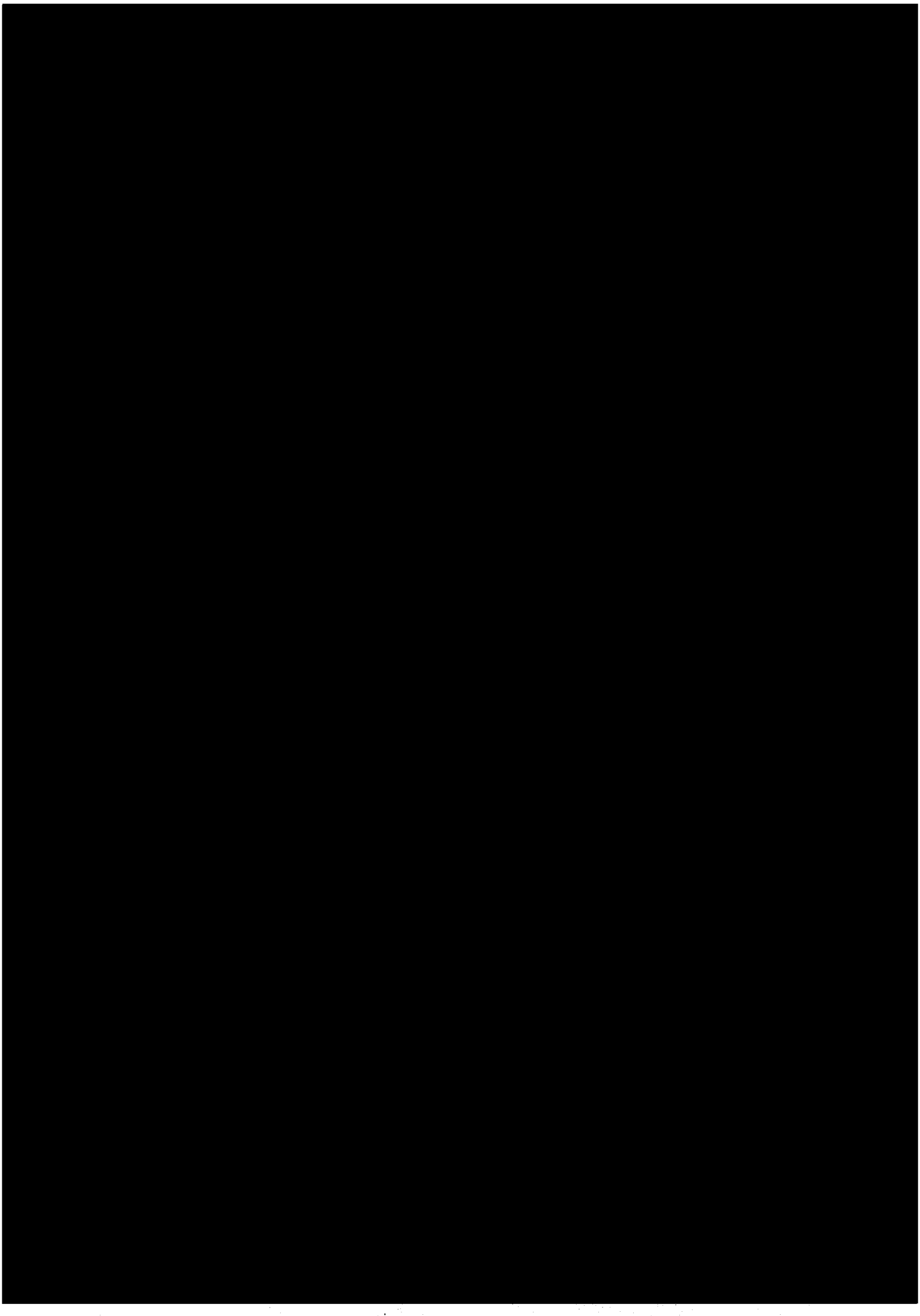
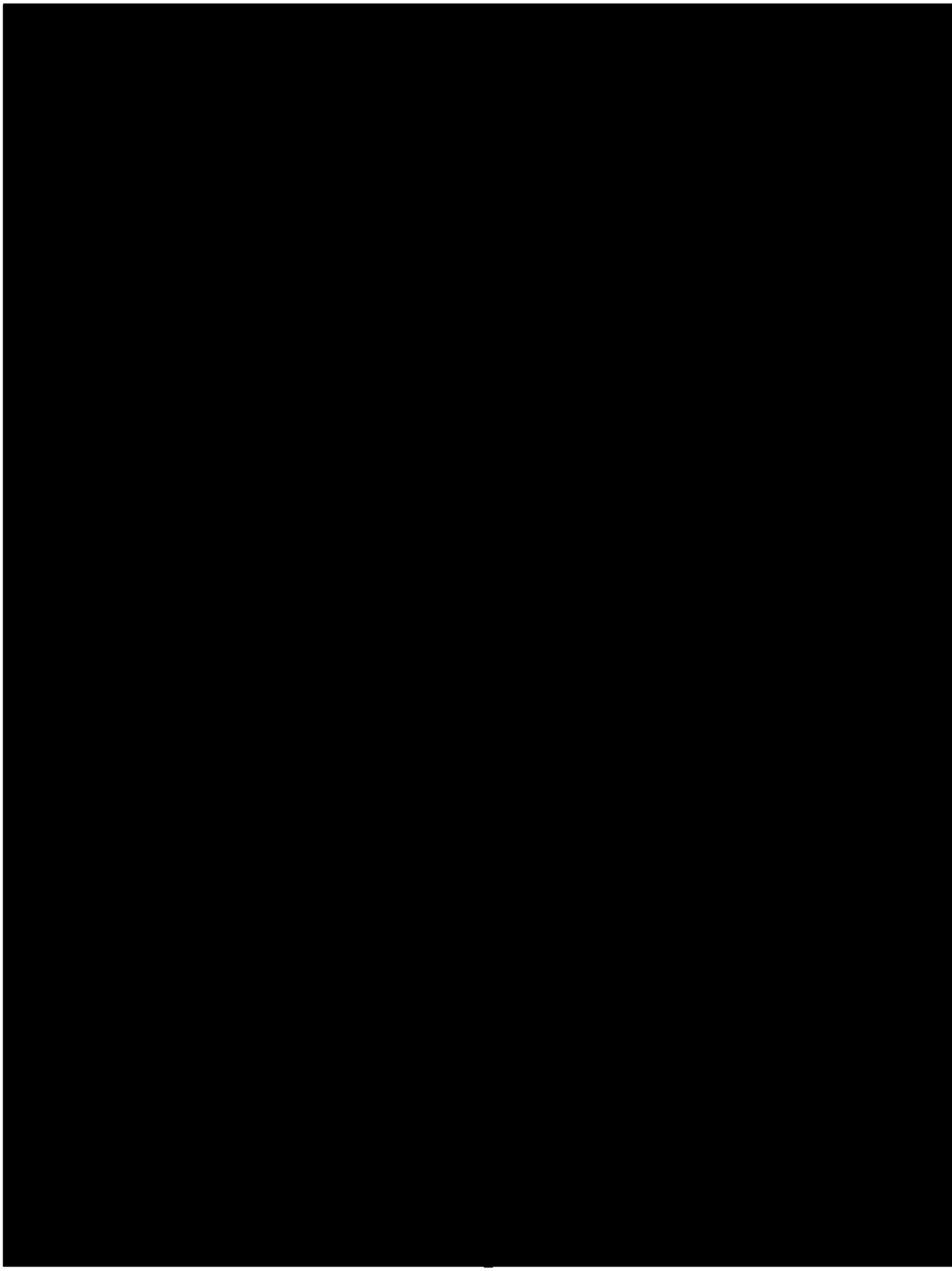
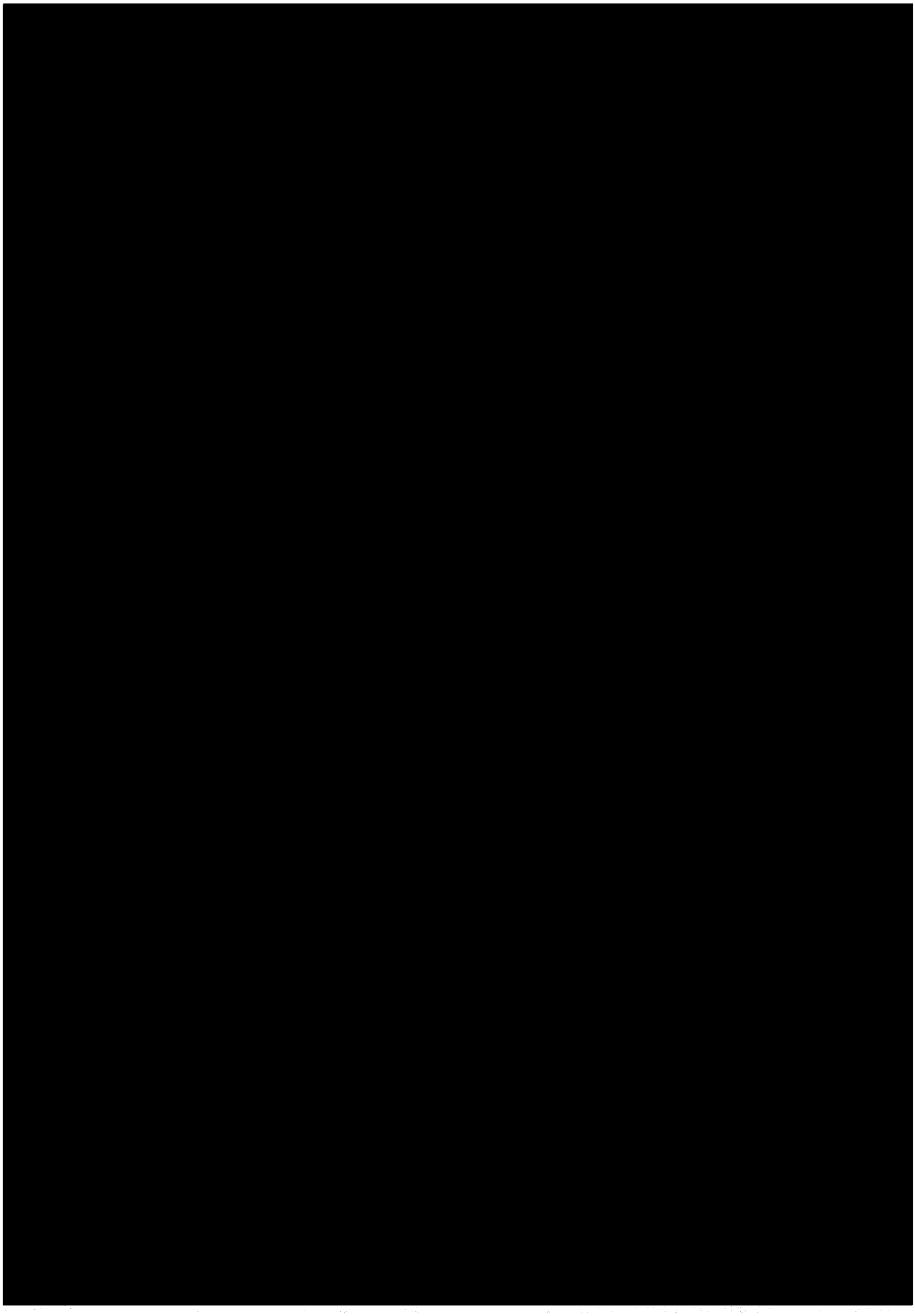
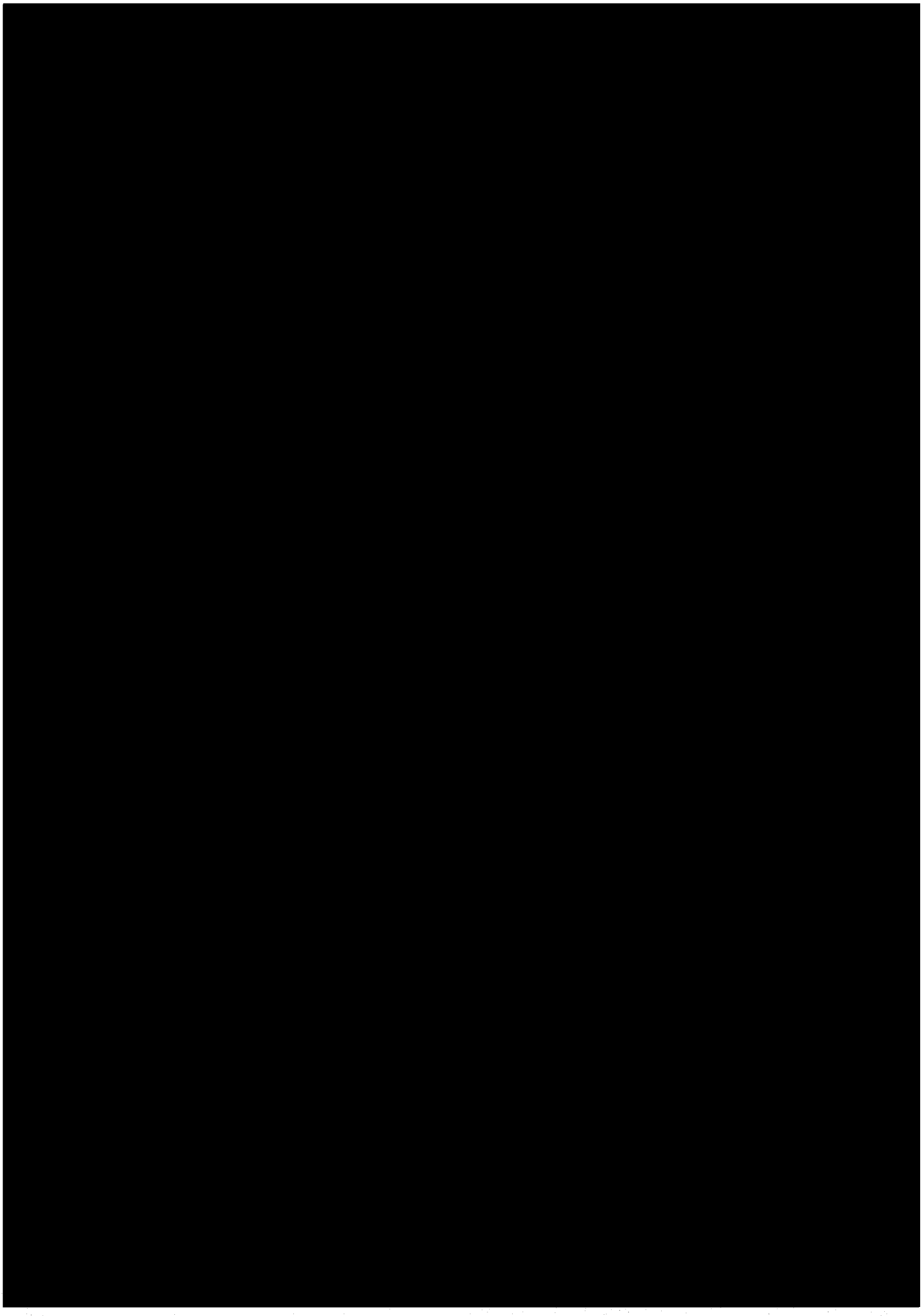
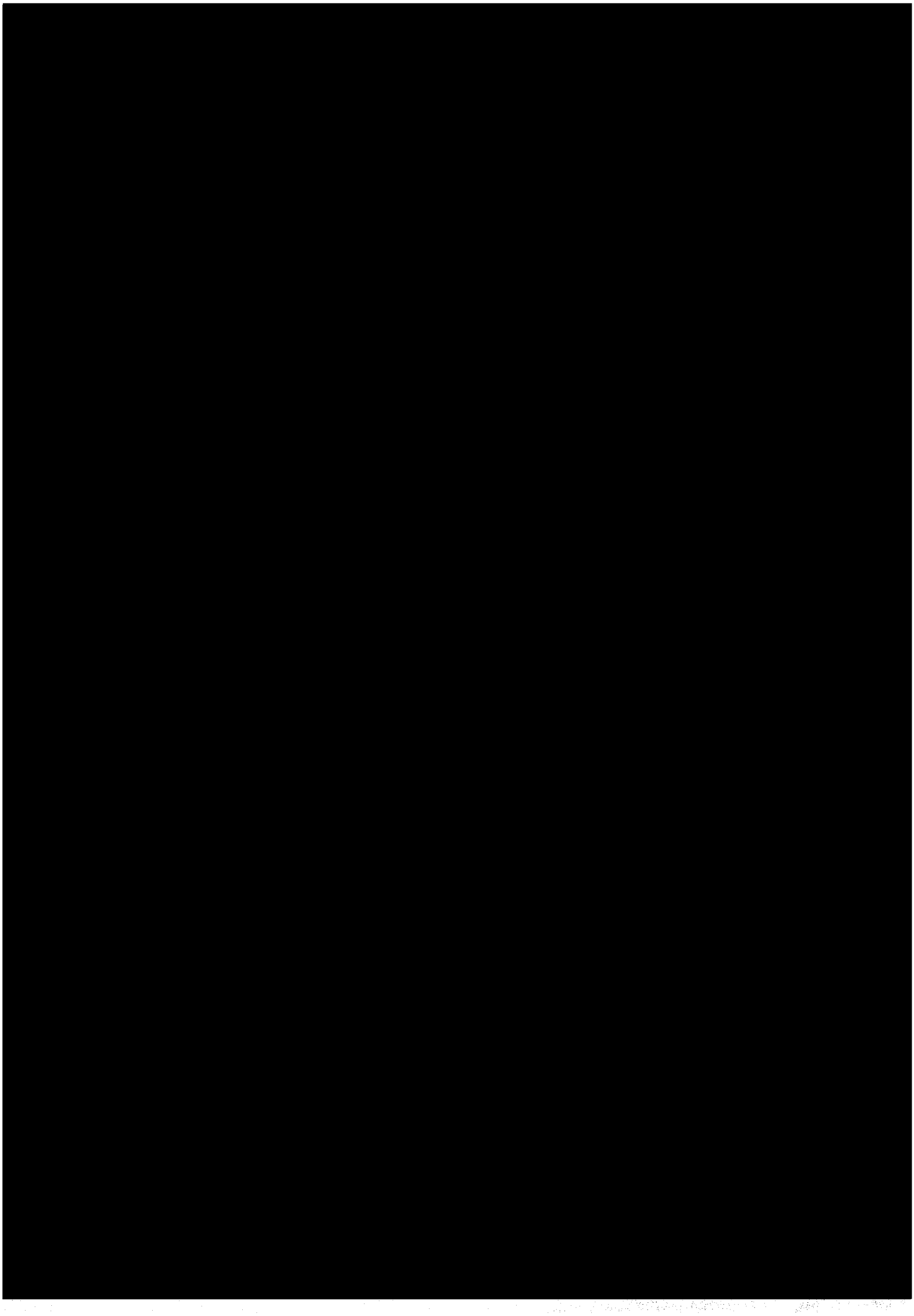










HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fareham Police Station
Quay Street
Fareham
Hampshire
P016 ONA

Tel. 0845 0454545
Fax. 023 92891663

Our Ref.

Your Ref.

21st June 2004

Ms L Quinn
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Dear Ms Quinn,

Re: Operation Rochester, Investigation into deaths of Patients at Gosport War Memorial Hospital

I am writing to you today to further update the GMC regarding the above investigation as promised at our meeting on the 27th February this year.

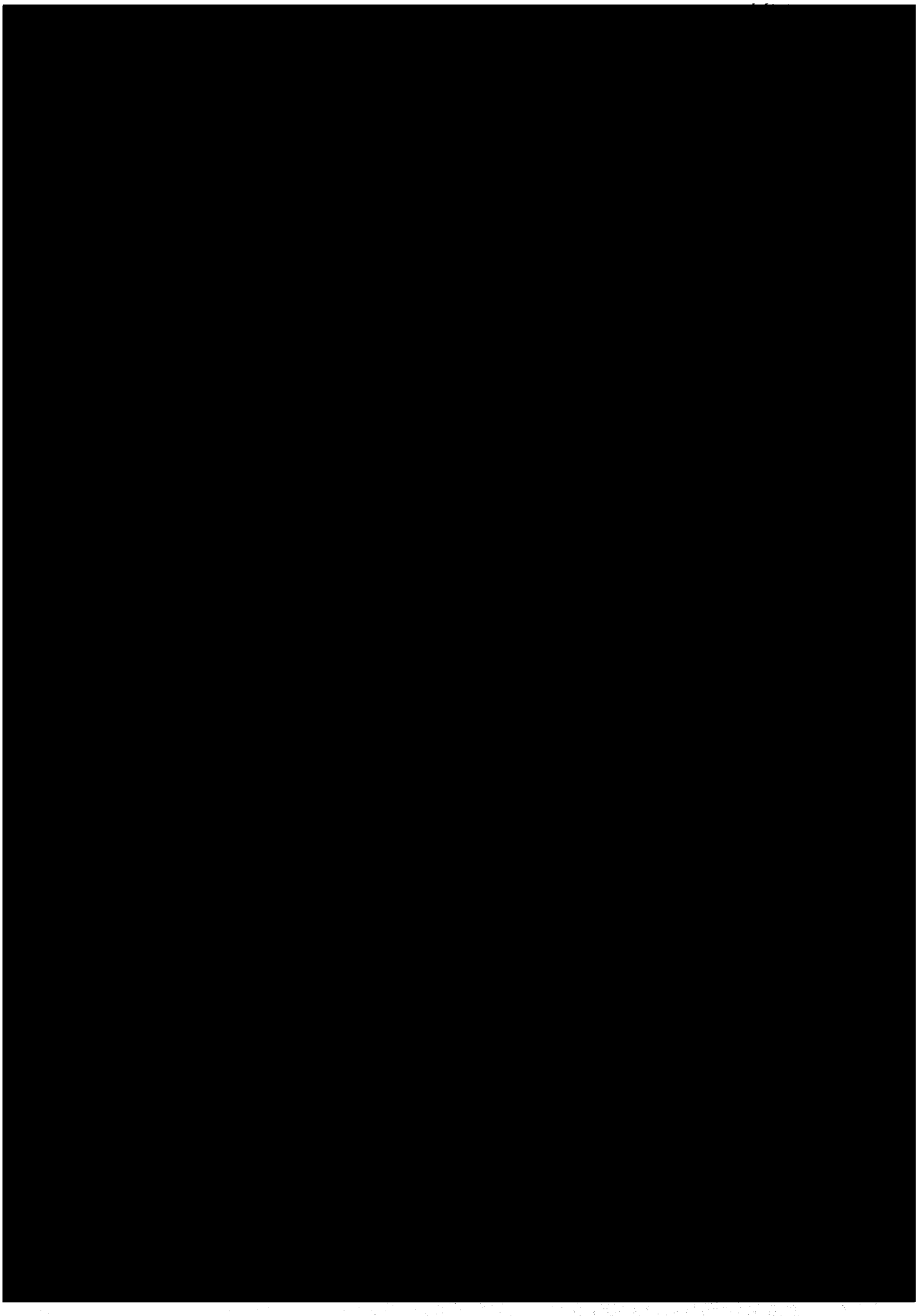
The police have now received the findings of the key clinical team in relation to the reported deaths of patients at the hospital and have prioritised the further investigation of a number of these cases. In respect of these cases we have identified a large number of key medical staff who we intend to interview and obtain witness statements from. It is possible that these interviews could be protracted and therefore take some time.

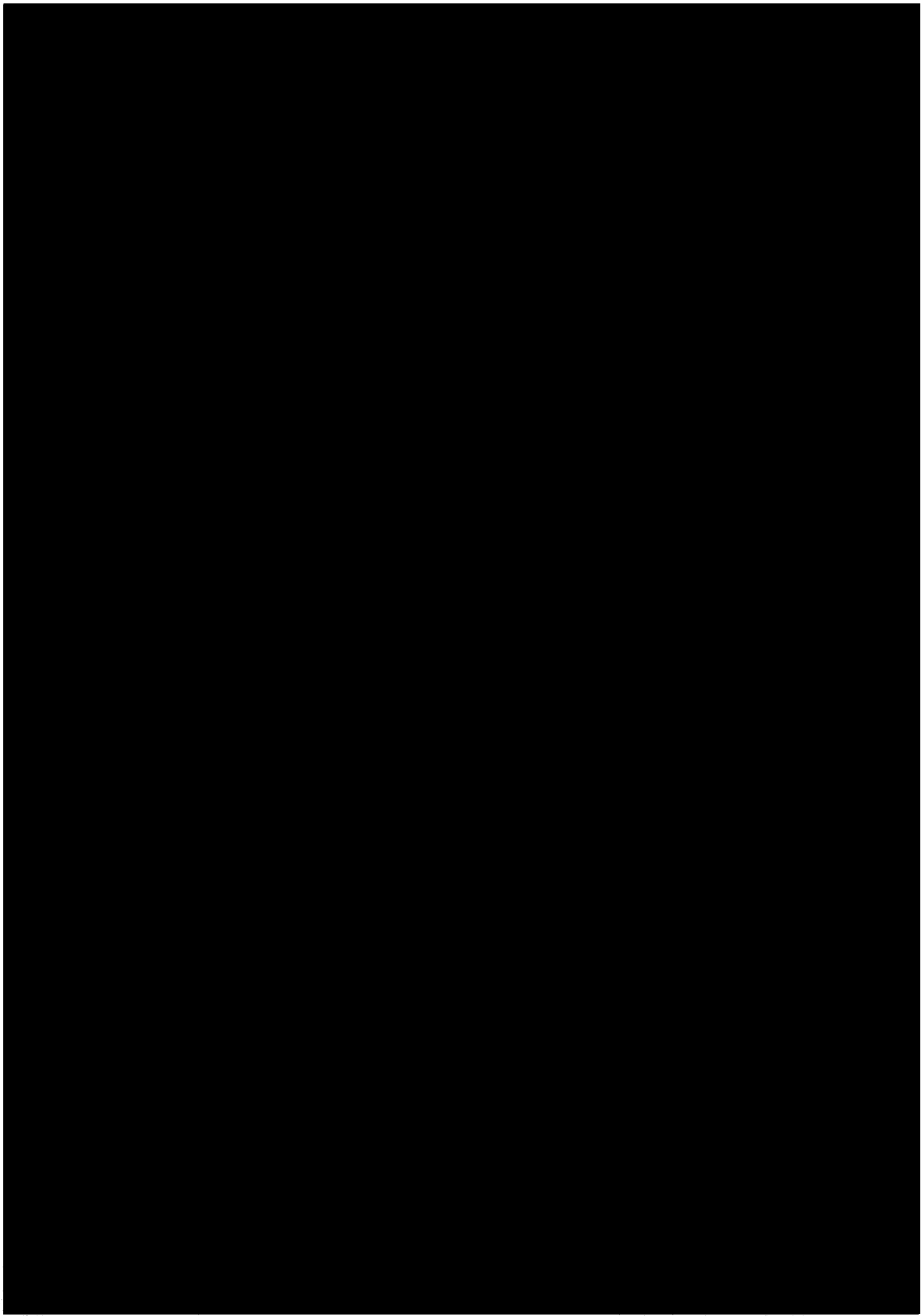
Once these statements have been obtained and reviewed they will be served on all the relevant parties. The police in consultation with the Crown Prosecution Service will at that stage seek to review our position in respect of disclosing these papers to you as soon as possible thereafter. This strategy has been discussed with the Chief Medical Officer who is in agreement with our course of action.

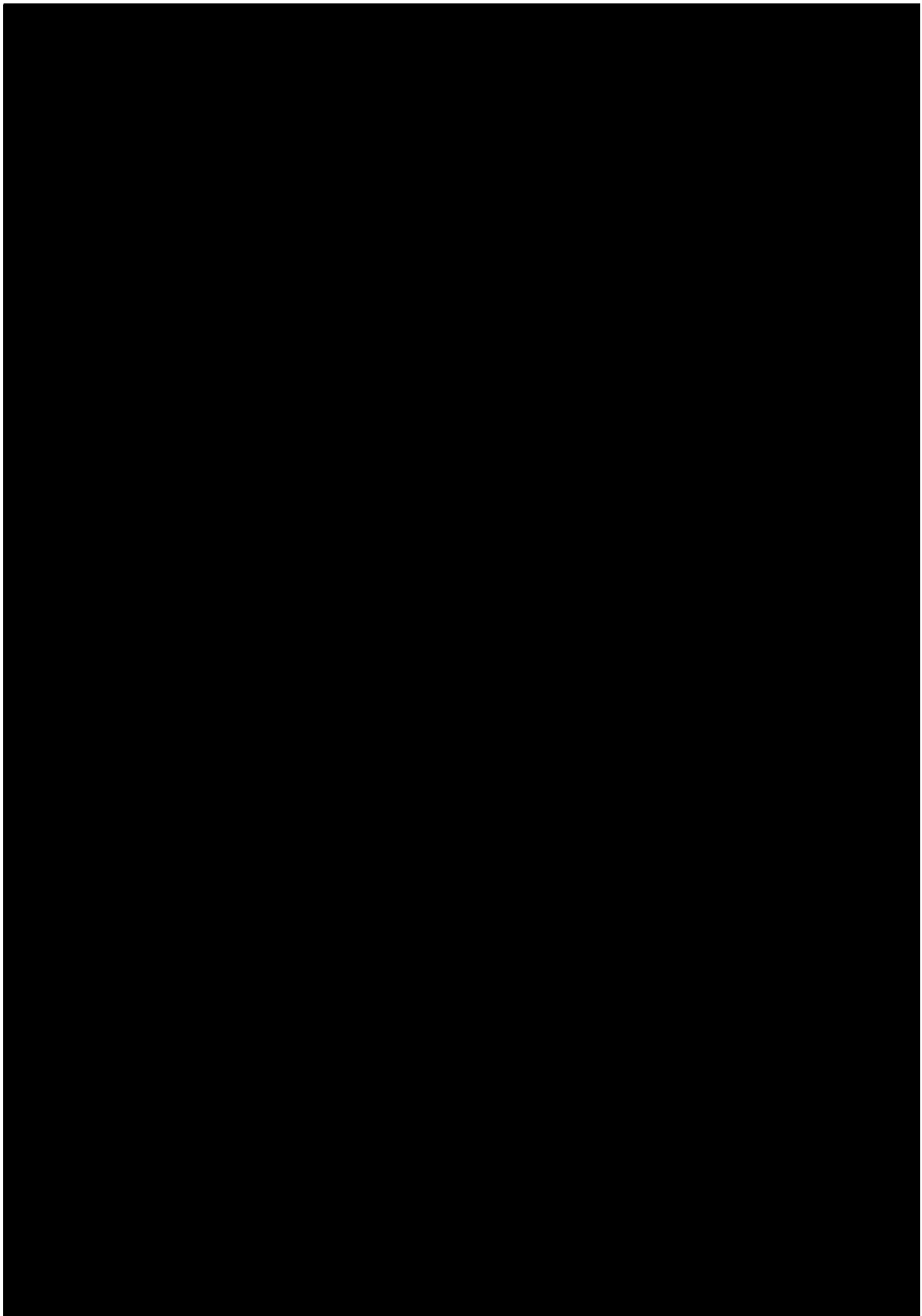
If there are any further questions that I can answer at this stage of the investigation please do not hesitate to contact me or any of my officers.

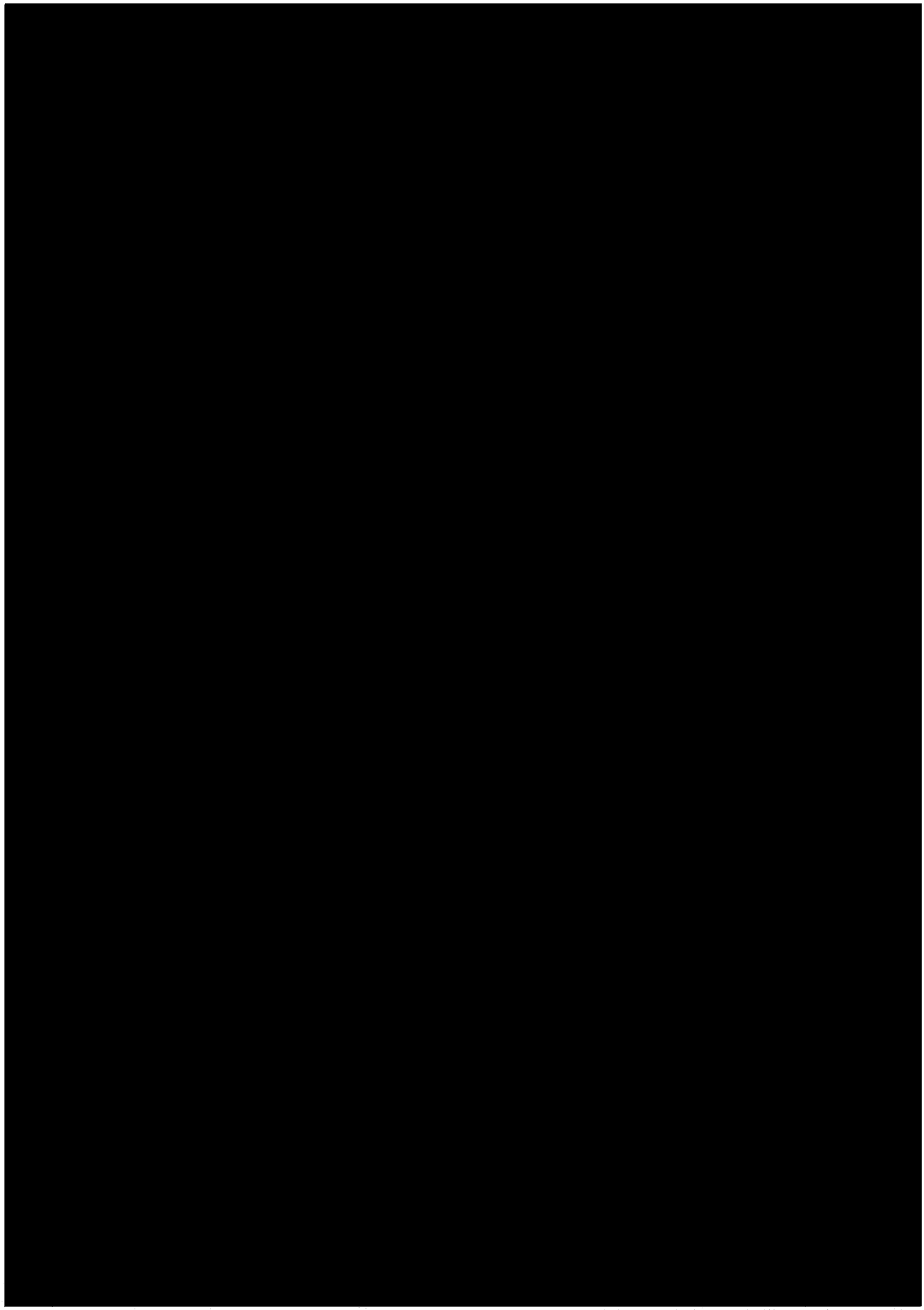
Yours Sincerely,

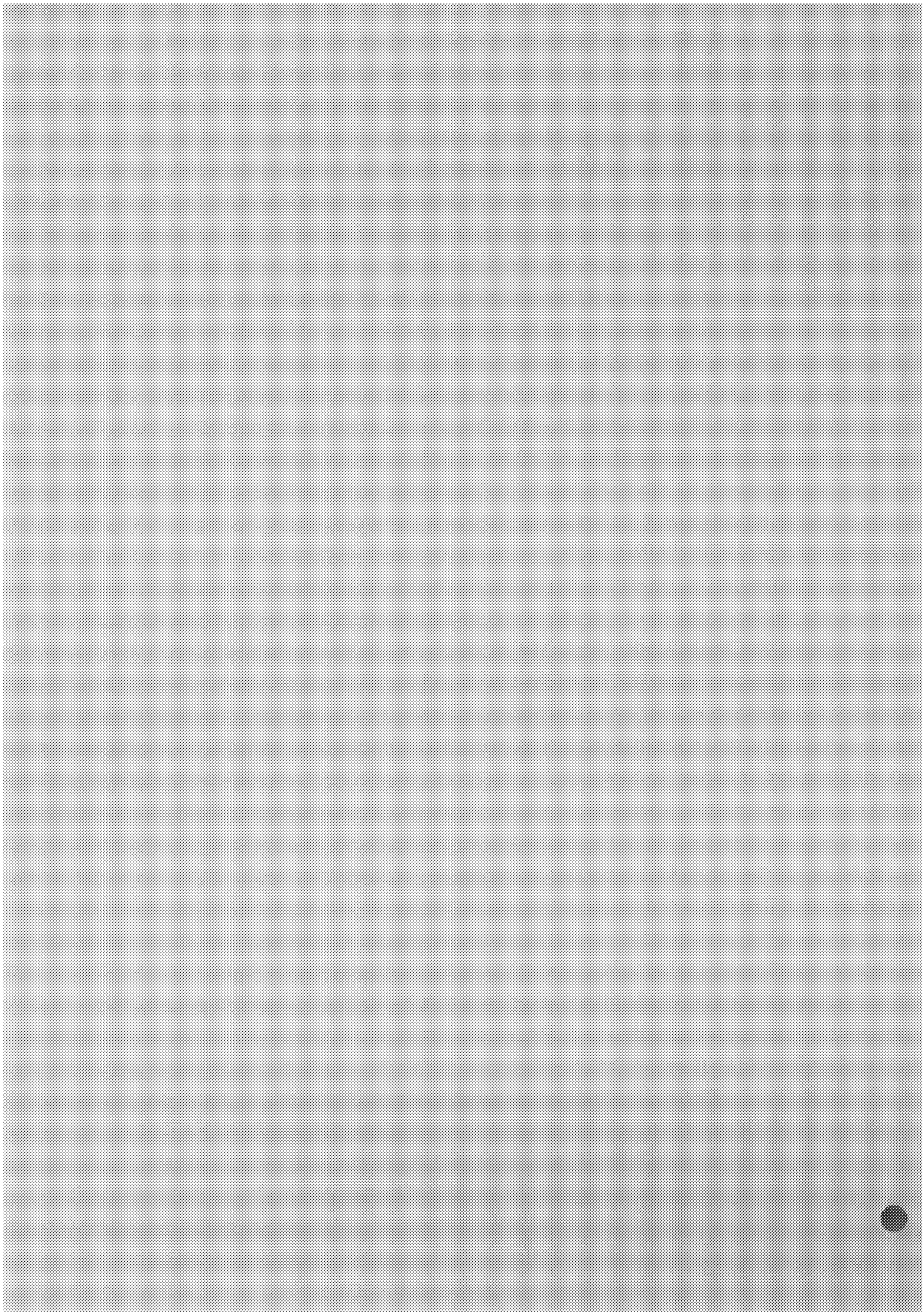
David Williams
Detective Chief Inspector











Paul Hylton Code A

From: Paul Hylton Code A
Sent: 17 Sep 2004 12:35
To: Paul Philip (Code A
Cc: Peter Swain
Subject: Dr Jane Barton

Importance: High

Paul

Please see attached.

Barton memo to Paul Philip 17-...

Paul

Memorandum

To **Paul Philip**

From **Paul Hylton**

Date **17 September 2004**

CC **Peter Swain**

Dr Jane Barton

1. I have now had an opportunity to review the information disclosed to the GMC by Hampshire Police on 10 September 2004. The information contains medical records, clinical team screening forms, reviews of expert reports, police officer reports and case reviews by Matthew Lohn, and relates to 19 cases in which the Police and medical experts have determined that the treatment by Dr Barton was "sub-optimal". Only one of those cases, that of Eva Page, has previously been considered by the IOC and PPC.

2. Critically, the police definition of sub-optimal treatment appears to be treatment that was neither negligent nor intended to cause harm. It could be argued that given the definition of spm as outlined in the case of *Preiss -v- General Dental Council*, it could not be properly arguable that sub-optimal treatment is capable of constituting spm. However, as these matters do not concern a single isolated incident it is difficult to see how *Preiss* could apply.

3. Having reviewed the information, it would appear that in respect of 14 of the 19 patients the expert's preliminary report indicates that it may be properly arguable that Dr Barton's alleged conduct is capable of constituting spm. I have based this opinion on the comments made in the Clinical screening forms and Matthew's reviews. What we do not have at this time are any detailed expert reports, and I am currently trying to ascertain from the Police whether there are any more detailed expert reports than those already disclosed. If there are more detailed reports available then we would have to consider whether we would need to put them before the IOC or whether the reviews we currently have are sufficient.

4. The information does not include details of the other four other cases previously considered by the IOC. I am currently trying to ascertain the status of these cases. However, given the nature of the albeit limited information previously made available to us by the Police it would not be unreasonable to assume that the other 4 cases are among those cases currently being considered by the CPS.

5. I will compile a bundle to be considered by the President for referral to the IOC next week. I will also contact the Police again in order to try and obtain

any information they feel able to disclose in respect of the cases currently being considered by the CPS. Clearly, it is important that we give the IOC as full a picture as possible of the matters under investigation. If nothing else, we should try and get from the Police a statement confirming that a criminal investigation is still taking place, outlining the broad nature of the allegations, and stating how many patients are involved.

Code A

Paul Hylton
Conduct Case Presentation Section

Upaate as at 7 May 04

2000/2047
Dr Jane Barton

Date of PPC referral to PCC: 28 August 2002

Considered by IOC on three occasions – June 2001, March 2002 and September 2002 – no order made

GMC solicitors: None at present

The GMC's case against Dr Barton began in July 2000 following referral by the Hampshire Constabulary which had started an investigation into the circumstances surrounding the death of Gladys Richards, a geriatric patient at Gosport War Memorial Hospital. The police investigation was subsequently extended to four other deaths, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

In February 2002, the Crown Prosecution Service decided against a criminal prosecution. At this point the relevant papers were disclosed to the GMC to decide on any issues of serious professional misconduct or seriously deficient performance. In August 2002, the case was referred by the GMC's Preliminary Proceedings Committee for hearing before the Professional Conduct Committee ('PCC').

The case has been referred to IOC on 3 occasions (June 2001, March 2002 and September 2002) for consideration of whether Dr Barton's registration should be restricted prior to hearing before the PCC.

On 28 May 2002, Mrs Mackenzie (daughter of the late Gladys Richards) wrote to the GMC. She copied the letter to David Blunkett MP, Hampshire Constabulary, Nigel Waterson MP, Peter Viggers MP, the Police Complaints Authority, the CPS and David Parry of Treasury Counsel. She was concerned about the failures of the police investigation. As a result, the police investigation was reopened. In July 2002, the then Commission for Healthcare Improvement published a report entitled "Gosport War Memorial Hospital Investigation into the Portsmouth Healthcare NHS Trust". The report did not name Dr Barton specifically, but referred to the criminal investigations and criticised the systems in place at the time.

On 30 July 2002, Mrs Mackenzie informed the GMC that the police were seeking advice from the CPS about the investigations and as a result were reconsidering the 5 cases. In November/December 2002, following discussions between the police and the CPS, it was decided that the police investigation should be continued and expanded, and FFW was asked to consider postponing the PCC hearing (which at that point was anticipated to take place in April 2003). Accordingly the case was removed from the GMC's lists.

On 30 September 2003, I met with the police who reported that the review of all the deaths of patients under Dr Barton's care at the hospital had suggested that the treatment of some 15 or 16 fell into the category of "negligence, cause of death unclear". At that point, the police anticipated interviewing Dr Barton, once a second team of experts had reviewed these cases, which they believed would be January 2004. They indicated that they were unable to provide full details of their

investigation, as this could jeopardise further investigations and the proposed interview of Dr Barton.

Until end September 2003, the GMC had been represented by FFW in this matter. However as Matthew Lohn had by that time been appointed by the police to assist in the quality control check on the experts findings, FFW withdrew from the GMC side to avoid and conflict of interest.

On 2 October 2003, I wrote to the police indicating that the GMC was considering referring Dr Barton's case yet again to the Interim Orders Committee and requesting a detailed written summary of the evidence they had obtained, including any report prepared by the team of experts. The police replied on 6 October 2003, confirming the content of their discussions with me on 30 September 2003 and stating: *"... our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegations such as those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton."*

A Medical Screener of the GMC again considered the case with a view to referring Dr Barton to the Interim Orders Committee in November 2003. However, the Screener felt that as a result of the lack of new evidence, the IOC would come to the same decision as previously.

On 7 January 2004, I wrote to the police, asking for an update on progress. They replied on 28 January 2004, indicating that they were unable to provide any further information at that point.

I wrote again on 6 February 2004 saying that the GMC had no further information about the case and that the GMC's inquiries were on hold pending conclusion of the police investigations.

On 27 February 2004 there was a meeting between the GMC (Paul Philip, Jackie Smtih and LQ), Hampshire Constabulary (DCS Watts and DI Niven) and FFW (Matthew Lohn). A summary of the police's position is that they were still investigating, did not know when the investigation would be complete, did not know when they would be ready to interview Dr Barton, and were not willing to give the GMC any of the information they have so far unless we guarantee not to pass it on to the doctor (which they know we cannot guarantee).

At Paul's request, Peter Steel wrote to the Hampshire Constabulary on 5 May 2004 setting out our position and asking when they think their investigations will be concluded, with what result, and to reconsider whether there is any information they can release to us now.

There is a patients' group in connection with Dr Barton's case, and it is represented by Alexander Harris.

Linda Quinn
7 May 2004

Was Lunds

Complaints on FPD against Dr Jane Barton

1. 2000/2047
Complainants
a. Hants Constabulary (R J Butt)
b. M Wilson
Category: dishonesty/criminality
Location of papers 10/6/04 Paul Hylton
Complaint 1, closed 11/2/02
Complaint 2, arrange PCC hearing 29/8/02
Complaint 43, closed 4/7/02

2. 2002/0553
Complainant: **Code A**
Category: substandard clinical practice/substandard treatment
Closed 10/6/02 (not SPM/SDP)
Location of papers: Recall

3. 2002/0941
Complainant: Marilyn Jackson
Category: other
29/8/02 arrange PCC conduct hearing
Location of papers: Paul Hylton

[complaint included complaints about
Phillip Beed (closed as not about a doctor)
Althea Lord (not SPM/SDP)]

4. 2002/1345
Complainant: R Carby
Category: dishonesty/criminality
Location of papers: Paul Hylton
16/4/04 "await outcome of criminal process"

5. 2003/1509
Complainant: **Code A**
No category listed
Location of papers: 7/10/03 – Recall
Closed 29/8/03 "as principal party does not wish to proceed"

smb 14/6/04

Andy
Need files
what are these
abt
Toni / Louise / Andy / Paul / Chris – meet
lunchtime 12.00.

Complaints on FPD against Dr Jane Barton

PH getting update from Linda
+
CM getting x 2 recall files.

1. **2000/2047**
Complainants
a. Hants Constabulary (R J Butt)
b. M Wilson
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Complainant: R Carby
Category: dishonesty/criminality
Location of papers: Paul Hylton
16/4/04 "await outcome of criminal process"

} Not added to cases at PCC, not at IOC as Info from IOC Sept 2002

5. **2003/1509**
Complainant: **Code A**
No category listed
Location of papers: 7/10/03 – Recall
Closed 29/8/03 "as principal party does not wish to proceed"

The Police insufficient (Nov 03)

smb 14/6/04

Paul Hylton Code A

From: Louise Povey Code A
Sent: 01 Jul 2004 16:31
To: Paul Philip Code A Toni Smerdon Code A ; Paul Hylton Code A
Cc: Peter Swain Code A
Subject: FW: Dr BARTON.

-----Original Message-----
From: Louise Povey Code A
Sent: 01 Jul 2004 16:30
To: Code A
Subject: RE: Dr BARTON.

Dear Mr Williams
This is very good news and I look forward to seeing you and DCS Steve Watts on Tuesday 6 July at 9am. Paul Philip (Director of Fitness to Practise), Toni Smerdon (Principal Legal Advisor) and Paul Hylton (Legal Assistant) will also be at the meeting. I note that you have to leave at 10am.

We are very pleased that you are now in a position to release information. Our immediate concern is whether this case should be referred to our Interim Orders Committee (IOC) which could limit the doctor's registration. Information which would assist us in this regard is the extent of the police's concerns (e.g. the patient names and number of cases the police are considering) and the reasons for those concerns. Would a police representative be willing to provide a statement for the IOC or attend the IOC meeting?

More generally, we would also be very interested to learn what information the police can disclose about its investigation, which witnesses/lines of enquiry would the police object to us pursuing and the future timetable of the case.

Yours

Louise Povey
Manager, Special Projects

-----Original Message-----
From: Code A
[mailto: Code A
Sent: 30 Jun 2004 12:03
To: Code A
Subject: Dr BARTON.

Mrs POVEY.

I have recently returned from leave.
I will be in London visiting the CPS on Tuesday the 6th July 2004.
I understand that you work Tuesdays and Thursdays.
Would you like to meet about 0900hrs to discuss ongoing investigations/timescales etc.

Regards.

Dave WILLIAMS.
Detective Chief Inspector.
Code A

2000/2047
Dr J A Barton

Chronology for GMC case (to 18 May 2004)

27/07/00	Hampshire Constabulary notify GMC of allegation by Gladys Richards' family that she had been unlawfully killed as a result of treatment received at Gosport War Memorial Hospital and confirmed that Dr Barton appeared to be responsible for her care.
June 2001	IOC considered and made no order.
February 2002	CPS decide not to proceed with criminal case. Disclosure to GMC of Crown's papers which includeda report on the management of a further four patients at Gosport War memorial Hospital.
21 March 2002	IOC considered again, including the additional information on the four patients, and made no order.
29 August 2002	PPC considered and referred the five cases to PCC.
August 2002	Police send their case papers to CPS because of concerns by family members that there was no case to be raised against Dr Barton.
19 September 2002	IOC considered and made no order.
19 September 2002	Hampshire and Isle of Wight NHS Health Authority sent to GMC a file of correspondence relating to concerns about the use of diamorphone on patients in 1991. GMC consulted Matthew Lohn as to whether this merited a further referral to IOC.
9 October 2002	Matthew Lohn replies that "... Screeners would be misdirecting themselves if, having seen the new papers, they were to refer the matter for further consideration by the IOC".
September/October 2002	Police reopened their investigation and the GMC's investigation put on hold. Police decide to investigate all deaths of patients under Dr Barton's care at the Hospital.

30 September 2003	Police meet with Linda Quinn, GMC, and said that following a review by experts, the findings in respect of the patients' deaths were that 25% were optimal, 50% were sub-optimal but causation unclear, 25% cause of death unclear (all percentages approximate). Police asked whether the case would be reconsidered by IOC on the basis of this information, but would not agree to disclose any of their papers because they knew that GMC would have to disclose to doctor if the case were to go back to IOC.
October 2003	Matter referred to Screener, with all available information. Screener does not consider that it should go back to IOC.
7 January 2004	LQ requests update on progress from police.
28 January 2004	Police indicate that unable to provide further information at that point.
6 February 2004	LQ confirms to police that GMC inquiries on hold pending conclusion of their investigations.
February 2004	Paul Philip meets with CMO, at CMO's request, to discuss Barton case and Richard Baker's report (which PP had not seen in advance of meeting).
27 February 2004	Meeting between GMC (Paul Philip, Jackie Smith and Linda Quinn), Hampshire Constabulary (DCS Watts, DI Niven and one other) and FFW (Matthew Lohn). To summarise police's position, they were still investigating, did not know when the investigation would be complete, did not know when they would be ready to interview Dr Barton, and were not willing to give the GMC any information/evidence unless the GMC guaranteed not to pass it on to Dr Barton.
5 May 2004	Peter Steel wrote to Hampshire Constabulary.

Linda Quinn Code A

From: Andrew Wood (Code A
Sent: 17 May 2004 10:47
To: Linda Quinn Code A
Subject: FW: Barton

Linda

Please note Matthew's e-mail below. I would be grateful if you could discuss with Matthew direct, regarding information he requires etc

Thanks

Andy

-----Original Message-----
From: Lohn, Matthew Code A
Sent: 14 May 2004 07:12
To: GMC - Andrew Wood (3670)
Subject: Barton

Andy

I know you are obtaining for me the documents relating to the correspondence with the Police. Could you also when sending the material over provide me with a copy of the IOC transcript and a short chronology of the GMC's handling of the matter.

Many thanks

Matthew

MATTHEW LOHN
Partner
Public and Regulatory Law
Code A
www.ffw.com

2000/2047
Dr Jane Barton

Date of PPC referral to PCC: 28 August 2002

Considered by IOC on three occasions – June 2001, March 2002 and September 2002 – no order made

GMC solicitors: None at present

The GMC's case against Dr Barton began in July 2000 following referral by the Hampshire Constabulary which had started an investigation into the circumstances surrounding the death of Gladys Richards, a geriatric patient at Gosport War Memorial Hospital. The police investigation was subsequently extended to four other deaths, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

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Until end September 2003, the GMC had been represented by FFW in this matter. However as Matthew Lohn had by that time been appointed by the police to assist in the quality control check on the experts findings, FFW withdrew from the GMC side to avoid and conflict of interest.

On 2 October 2003, I wrote to the police indicating that the GMC was considering referring Dr Barton's case yet again to the Interim Orders Committee and requesting a detailed written summary of the evidence they had obtained, including any report prepared by the team of experts. The police replied on 6 October 2003, confirming the content of their discussions with me on 30 September 2003 and stating: *"... our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegations such as those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton."*

A Medical Screener of the GMC again considered the case with a view to referring Dr Barton to the Interim Orders Committee in November 2003. However, the Screener felt that as a result of the lack of new evidence, the IOC would come to the same decision as previously.

On 7 January 2004, I wrote to the police, asking for an update on progress. They replied on 28 January 2004, indicating that they were unable to provide any further information at that point.

I wrote again on 6 February 2004 saying that the GMC had no further information about the case and that the GMC's inquiries were on hold pending conclusion of the police investigations.

On 27 February 2004 there was a meeting between the GMC (Paul Philip, Jackie Smtih and LQ), Hampshire Constabulary (DCS Watts and DI Niven) and FFW (Matthew Lohn). A summary of the police's position is that they were still investigating, did not know when the investigation would be complete, did not know when they would be ready to interview Dr Barton, and were not willing to give the GMC any of the information they have so far unless we guarantee not to pass it on to the doctor (which they know we cannot guarantee).

At Paul's request, Peter Steel wrote to the Hampshire Constabulary on 5 May 2004 setting out our position and asking when they think their investigations will be concluded, with what result, and to reconsider whether there is any information they can release to us now.

There is a patients' group in connection with Dr Barton's case, and it is represented by Alexander Harris.

Linda Quinn
7 May 2004

[redacted]

Linda Quinn Code A

From: Paul Philip (Code A
Sent: 15 Mar 2004 15:52
To: Linda Quinn (Code A Jackie Smith Code A
Subject: Re: Dr Barton

Linda,

Thank's for this. Could you chase up Mary in relation to her writting the letter I wanted to send to the police.

Thanks

Paul

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Linda Quinn (Code A
To: Paul Philip Code A Jackie Smith Code A
Code A
Sent: Mon Mar 15 15:16:00 2004
Subject: Dr Barton

Paul, Jackie

I have checked the Barton files to ascertain what we know about Dr Barton having made a voluntary undertaing not to prescribe opiates and benzodiazepines. From our information, it does not appear that she is subject to any undertaking at present, although she has been in the past, as follows:

We have a copy of a letter from Dr Old, Acting Chief Exec of the Health Authority, to Dr Barton, dated 13 February 2002, in which it is noted that Dr Old and Dr Barton had agreed on 12 February 2002 that she "would voluntarily stop prescribing opiates and benzodiazepines with immediate effect" and that "We were unable to put a timescale on these restrictions but agreed to review the situation monthly." On 21 March 2002 Dr Barton confirmed to IOC under oath that she was "not prescribing any opiates or benzodiazepines at the moment".

At IOC in September 2002 Dr Barton's counsel informed the Committee that Dr Barton "continues to work full time as a GP subject to other matters. She does not routinely prescribe benzodiazepines or opiates." Counsel then referred to the condition Dr Barton had previously agreed with the Health Authority and said that the HA had lifted the condition. He then noted that that was the only change in Dr Barton's circumstances since March 2002.

We have had not information on this prescribing point since the last IOC meeting in September 2002.

However I have recently clarified with Fareham and Gosport PCT Dr Barton's relationship with the Gosport War memorial Hospital. They have confirmed that Dr Barton was never an employee of the hospital, but that her GP practice is part of a bed fund (enabling local GP practices to admit their patients for appropriate care, supervised by the GP and paid for by the PCT. Approximately 19 months ago Dr Barton agreed voluntarily not to admit patients to the hospital nor supervise any patients n the hospital, and this is the current position.

I will confirm to the police that Dr Barton has not made any voluntary undertaking to the GMC.

Linda

Linda Quinn Code A

From: Linda Quinn Code A
Sent: 15 Mar 2004 15:16
To: Paul Philip Code A Jackie Smith Code A
Subject: Dr Barton

Paul, Jackie

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I will confirm to the police that Dr Barton has not made any voluntary undertaking to the GMC.

Linda

Isle of Wight, Portsmouth and South East Hampshire
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Direct Line Code A
Direct Fax

Tel: 023 9283 8340
Fax: 023 9273 3292

Our Ref: PO/JD/021302jb.doc

13 February 2002

Private & Confidential
Dr Jane Barton

Code A

Dear Dr Barton

Following our meeting last night I wish to set out the basis of our agreement. I have shared this letter with Dr Ian Reid since it relates, in part, to the Gosport War Memorial Hospital.

- We agreed that you would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital.
- We agreed that you would voluntarily stop prescribing opiates and benzodiazepines with immediate effect.
- We were unable to put a timescale on these restrictions but agreed to review the situation monthly.

In view of the anticipated press interest, the Health Authority and Portsmouth HealthCare NHS Trust have prepared a draft statement which we have attached for your perusal.

Many thanks for your co-operation.

Yours sincerely

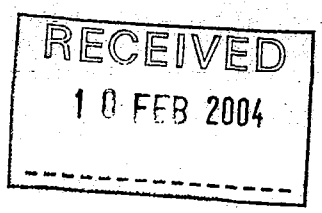
Code A

pp Dr Peter Old
Acting Chief Executive

Code A

Attachment

Fareham and Gosport NHS
Primary Care Trust



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

Tel: 01329 233447
Fax: 01329 234984

Ms Linda Quinn
Senior Case Worker
General Medical Council
Fitness To Practice Directorate
178 Great Portland Street
LONDON
W1W 5JE

9 February 2004

Dear Ms Quinn

Further to my telephone conversation with you today, I can confirm that the practice in which Dr Jane Barton (a local GP in the Gosport area) is based is part of a 'bed fund'. This fund is designed to enable local GP practices to admit their patients for appropriate care, supervised by the GP, paid for by the PCT as a service.

Approximately, 18 months ago Dr Barton agreed voluntarily not to admit patients to the hospital nor supervise any patients in the hospital.

This is the current position and it has not changed over time.

As Dr Barton is a GP her relationship with the PCT is one of providing a service for which payment is made, consequently she is not an employee and the issue of suspension in any form does not apply in this case.

I trust this clarifies matters. Please contact myself or Ms Fiona Cameron, Director of Nursing and Clinical Governance should you require any further information.

Yours sincerely

Code A

Alan Pickering
Deputy Chief Executive

Linda Quinn Code A

From: Jackie Smith Code A
Sent: 12 Feb 2004 07:48
To: Linda Quinn Code A
Subject: FW: Dr Barton and a report from Prof Baker

Linda

Please see below.

Jackie

-----Original Message-----
From: Paul Philip Code A
Sent: 11 Feb 2004 21:02
To: Neil Marshall Code A; Sheila Bennett Code A;
Jackie Smith Code A; Toni Smerdon Code A; Christine
Couchman Code A; Blake Dobson Code A
Subject: Dr Barton and a report from Prof Baker

Dear all,

I met the CMO this morning to discuss the case of Dr Barton. He agreed to share with me the report prepared by Prof Baker on this matter. He is doing so in complete confidence and without any concent for us to use it or in anyway disclose this to the doctor. This means that we cannot use it to trigger a further referal to the IOC, which I understand would not be merited on its content in any event.

Should this arrive whilst I am on leave please keep hold of it and do not in any circumstances put this into our process.

Neil could you let Peter L know this and Jackie Linda Quinn. Likewise Blake with his CWMs. We must ensure this is not disclosed outside the GMC.

Paul

Sent from my BlackBerry Wireless Handheld

Linda Quinn Code A

From: Linda Quinn Code A
Sent: 10 Feb 2004 14:52
To: Toni Smerdon Code A
Subject: Dr Barton

I handed to you yesterday a recent letter from the police. Today I have had a telephone call from them and attach my note of that call.

phone
-hampshire constab

Linda

GMC Legal

TELEPHONE NOTE (LF5)

1.	DATE:	10 February 2004
2.	TIME:	12:00
3.	FROM:	D I Nigel Niven, Hampshire Constabulary
4.	TO:	Linda Quinn
5.	RE:	Dr J Barton
6.	MESSAGE:	

DI Niven rang to inform me that, following the categorisation of the deaths (see file note of 30.9.03) and the completion of the quality assurance check by Matthew Lohn, he would be contacting the families this week to inform them as to which category was applicable to their deceased relative. Some people had requested letters, others had requested personal visits. DI Niven will send letters on Wednesday, 11 February 2004, and be making the personal visits on the Thursday. He has notified us as a courtesy, in case any of the families involve the press.

DI Niven said that it is effectively the end of the process for some of the families, but he will be explaining that they may be asked for medical records etc by the GMC or the Nursing regulatory body in the future, and he said he would seek permission now, while informing people of decisions, to be able to pass on such documents in the future.

We agreed that it might be useful for us to meet in March.

7	TIME ENGAGED ON CALL:	5 mins

5.2.04

Dr Barton

Alan Pickering

Gosport PCT?

Bed Fund

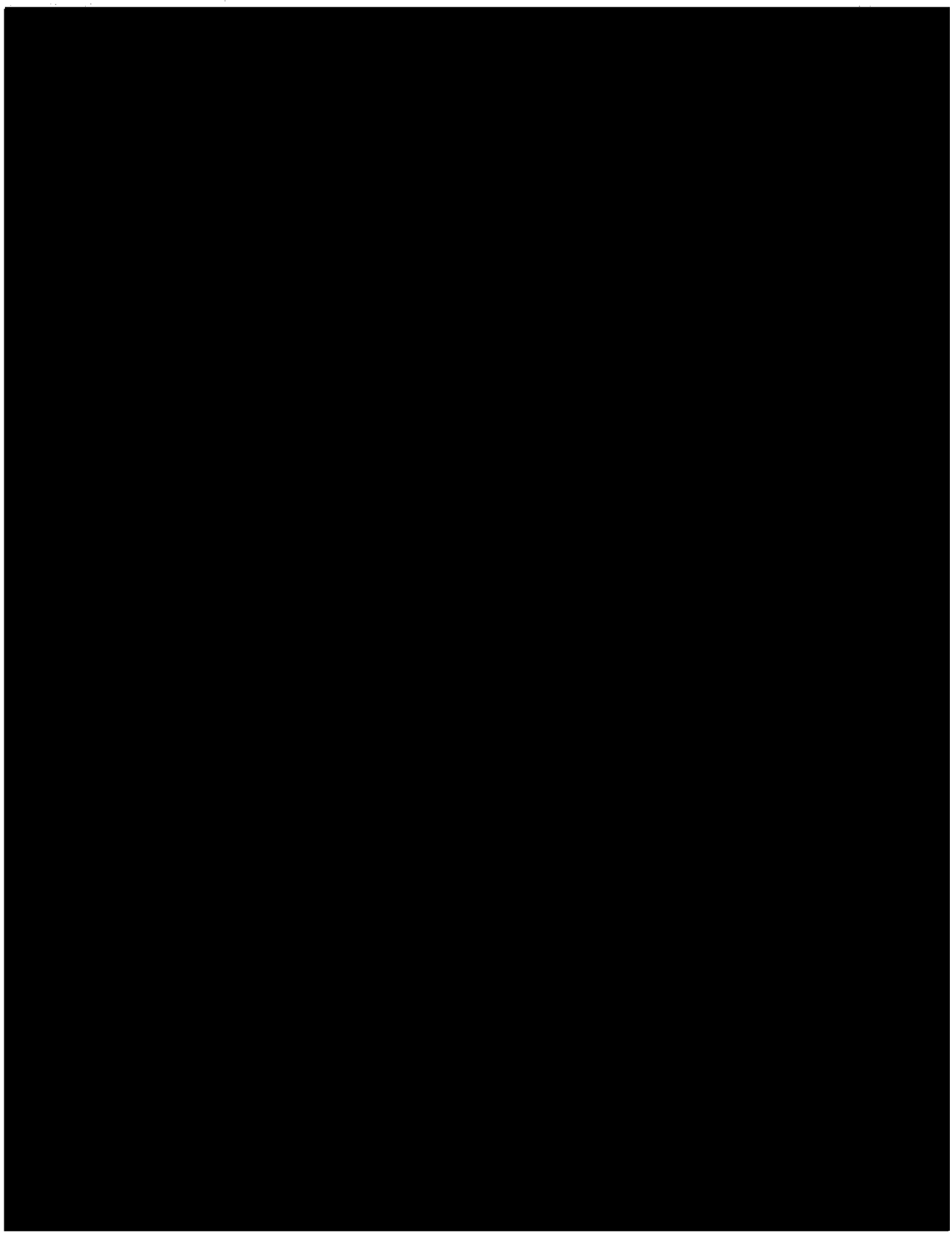
CCP beds, they can admit to.

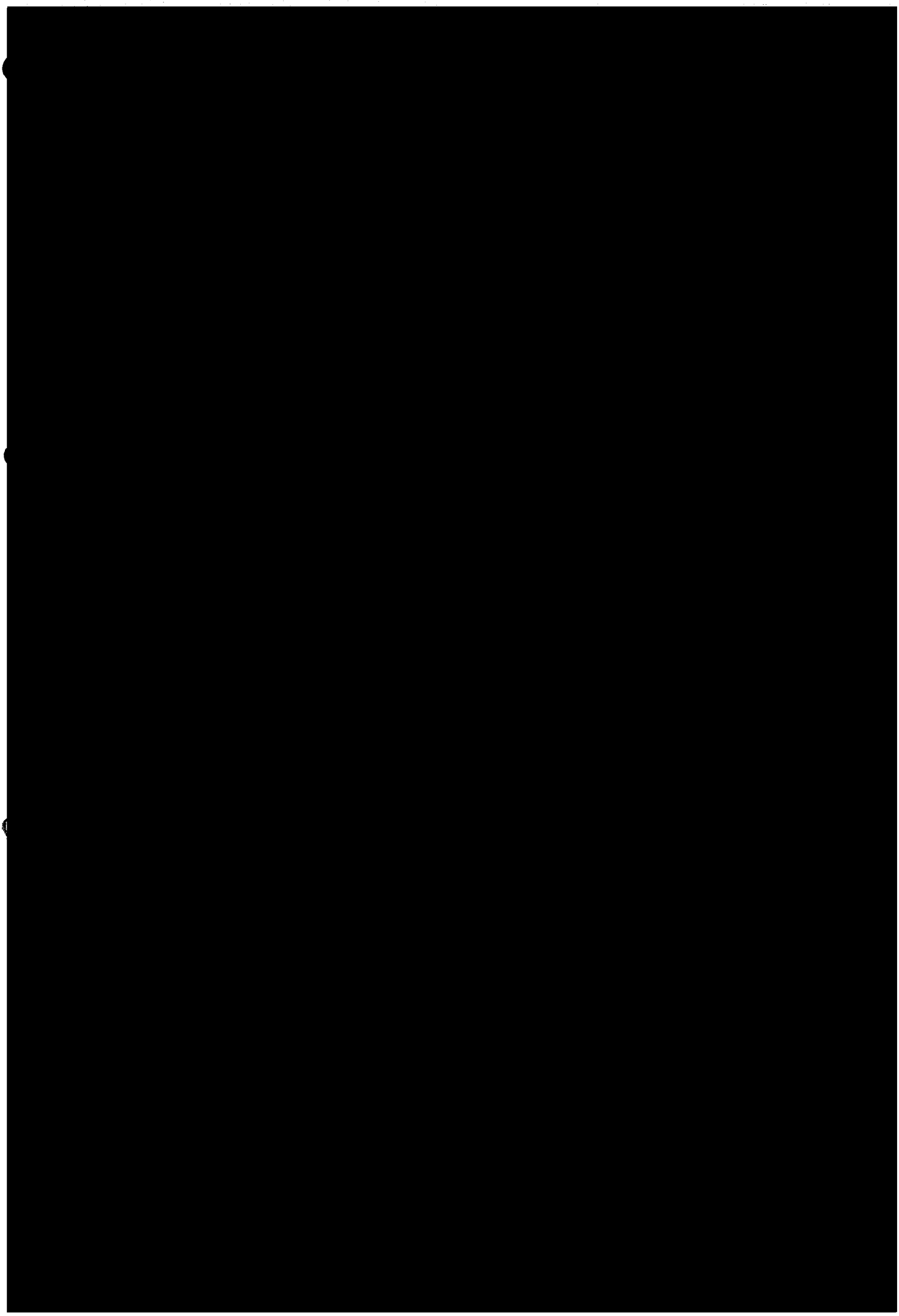
Voluntarily agreed not to admit, and not dealing with patients at the hospital.

PCT pays CCPs to alter their patients in work hosp. bed.

Fridge

[redacted]





GMC Legal

TELEPHONE NOTE (LF5)

1.	DATE:	3 December 2003
2.	TIME:	14:20
3.	FROM:	Linda Quinn
4.	TO:	Mike Evans of DoH Investigation and Inquiries Unit
5.	RE:	Dr J A Barton
6.	MESSAGE:	

After ensuring that Professor Richard Baker's report/audit in respect of the Gosport War Memorial Hospital was not already with the GMC, I telephoned Mike Evans as his name accompanied the 13 September 2002 press release about the audit. I left a message and Mike Evans subsequently rang me back

I enquired about the report and by way of explanation, said that my director had been invited to meet with the Chief Medical Officer "in the light of the report".

Mike Evans was aware of this. He confirmed to me that the GMC had not received the report, and added that it would not be issued to us at this stage. He said that the only people who had copies were the CMO and himself. I expressed surprise, having earlier been told by the Hampshire Constabulary that they and the Strategic Health Authority had copies. Mike Evans then said that these two organisations did in fact have copies. However, it was not intended to publish the report, or to circulate it wider on a confidential basis. One reason given by Mike Evans was that the Police investigation must not be prejudiced. I commented that it could be difficult for our Fitness to Practise Director to discuss aspects of the report if he had not had an opportunity to read it.

Mike Evans said the purpose of the meeting was for the CMO to outline the issues raised in the report and agree with Paul /the GMC the best way forward. He added that the report was as a result of an audit of the papers, rather than an investigation, but it reached some fairly strong conclusions. The CMO wished to discuss with Paul the thrust of Professor Baker's findings and whether they raise sufficient cause for concern for decisions already taken to be reversed. If so, how would this be done. (I was not entirely sure to what he was alluding, but following our next exchange it seemed to be clear that he was talking about the IOC decisions of no order.)

I pointed out that Dr Barton was still practising and said that I was aware that the meeting was currently set for 12 January 2004. I asked if, given Professor Baker's conclusions, decisions on the way forward and possible GMC action could wait until then. Mike Evans said this had been considered and that any such decisions could wait.

Mike Evans emphasised that the meeting was for the CMO to impart information, and for GMC processes to be discussed in a broad way, to ascertain what further could be done which fitted with our processes.

I thanked Mike Evans for the information, and said that we may need to contact him again (to which he was very agreeable).

Signed: Linda Quinn **Code A** 4·12·03

GMC Legal

TELEPHONE NOTE (LF5)

1.	DATE:	3 December 2003
2.	TIME:	12:30
3.	FROM:	DS Owen KENNY, Case Officer, Hampshire Constabulary Code A Code A
4.	TO:	Linda Quinn
5.	RE:	Dr J A Barton
6.	MESSAGE:	DS Kenny telephoned me in response to the message I had left earlier with D C S Watts' secretary. I asked if Hampshire Constabulary had a copy of the report by Professor Richard Baker. DS Kenny said they did, but that it was highly confidential and a numbered copy had been issued to them. He also told me that a copy had been issued to the Strategic Health Authority. He did not think the GMC had a copy. On the front cover was noted "Final Version, October 2003". DS Kenny said he could not copy his report to us. I assured him that I fully realised this, and said I would approach the DoH about it. As he is Case Officer, we exchanged contact details.
7	TIME ENGAGED ON CALL:	5 mins

Code A

4.12.03

Linda Quinn Code A

From: Linda Quinn Code A
Sent: 03 Dec 2003 16:17
To: Blake Dobson Code A
Subject: Dr Barton

Blake - a brief note to keep you posted. I will do a full phone note before I leave today.

Having discovered that the Baker report/audit had been finalised only in October 2003, I tried everywhere possible within the GMC in case it was sitting in someone's tray, and then rang the DoH Investigations Unit. Mike Evans there told me that the GMC did not have a copy, and would not be given one.

My fuller note will give you the reasoning behaind this, and my responses.

I know the meeting is fixed for 12 Jan, so hope you don't mind waiting an extra hour or so!

Linda

Linda Quinn Code A

From: Blake Dobson Code A
Sent: 03 Dec 2003 09:41
To: Linda Quinn Code A
Subject: FW: Gosport War Memorial Hospital

-----Original Message-----
From: Blake Dobson Code A
Sent: 03 Dec 2003 09:35
To: Blake Dobson (Man - Code A (E-mail)
Subject: Gosport War Memorial Hospital

Linda,

to summarise my interest, further to an invite to Paul Philip to discuss this case with the CMO he asked me to find out re a reply to our letter of 2/10/03 to Hampshire police and the issue of the "Baker report".

We did receive a reply on 13th October. The police said:

- they are investigating a significant number of deaths at GWMH where experts have taken the view that care (implied Dr Barton's) was negligent
- they cannot disclose information to us if it will in turn be disclosed to Dr B, although they would appreciate reassurance from us that we could avoid passing this information to her and on this basis might work more closely with us
- on this basis they think further assessment is required in relation to the risk that Dr B poses to patients, given that their investigation centred only on GWMH
- that we would be aware that Prof Richard Baker was tasked with conducting some analysis by the CMO with a wider remit than theirs and outcome unknown (to the police). The police imagined that any conclusions he reached might be useful to us in our deliberations.
- They will need to interview Dr B at length again
- They look forward to hearing from us so we can discuss how to progress the matter further.

Subsequently, on 5th November, Wendy screened this cases again for an IOC referral and felt referral inappropriate. I assume Wendy had the letter from the police in her possession? – Yes. / No Done

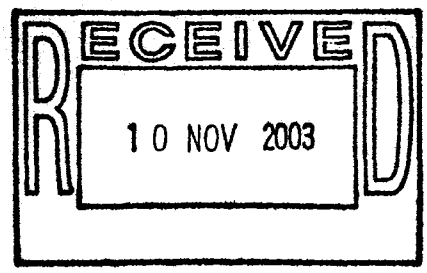
You are going to let me know whether we have this Baker report on file or not. If we do, did Wendy see it? If not, is there any other reference to it within the papers or dialogue with the CMO's office?

Given the police's letter we need to consider how we respond quickly. Perhaps you could let me know how you propose to respond? I am concerned that the police say quite clearly that they think further assessment is required in relation to the risk posed to patients, presumeably through Dr B continuing to practise as a GP. If we disagree we need to be clear on why we disagree.

Many thanks for your help, please can you let me know today?

Blake.

F



Case 469 2000/2047 (Manchester)
Received 5.11.03. returned 6.11.03
Dr Barton vs Hampshire Constabulary

Dear Linda,

Thank you for referring this case which has already been referred to the PCC but postponed whilst the Police continue their enquiries. This doctor has already been referred to the IOC in June 2001 in respect of one case, In Feb 2002 when the CPS decided to take no action but papers were disclosed to the GMC about 4 patients who had died in Gosport Wae Memorial Hospital and in September 2002 by the president after PPC had referred to PCC but not IOC and on each occasion no order was made.

Taking into account Matthew Lohn's opinion at para 11 of Toni Smerdon's memorandum, her opinion and the lack of new evidence as the police do not want to disclose anything which may prejudice their case I do not think we should send this case to IOC again.

The doctor is not a danger to the public as she has never had any complaints about her GP work and she has voluntarily agreed to restrict her prescribing of certain drugs. She has resigned from her post at Gosport War Memorial Hospital.
If and when the police charge Dr Barton it would be reasonable to send to IOC but in the absence of new evidence I think the same advice would come from the legal assessor as before

I agree that the office should keep the matter under review and refer back if new evidence is disclosed by the police or Dr Barton is formally charged WDS 6.11.03.

Code A

no SOF4 enclosed - if you want me to sign send on its own

Memorandum

To **FTP Screener**

From **Linda Quinn**
Conduct Case
Presentation Section
Code A

Date **27 October 2003**

Copy **Jackie Smith**

Dr J A Barton (2000/2047)

1. I write to give you an update on this case and to seek your view as to whether the matter should be submitted to IOC.

2. I attach a copy of the IOC item prepared for 19 September 2002, when the IOC determined not to make an order restricting Dr Barton's practice (flag 4).

3. I have recently met with the police who wished to provide the GMC with an update as to their investigations. My note of that meeting is at flag 1.

4. I also attach, at flag 2, a memorandum from Toni Smerdon, In-House Legal Team:

   a. Paragraphs 2 to 11 give background to the current position, including the outcome of three referrals of the matter to IOC between June 2001 and September 2002;

   b. Paragraphs 12 to 17 cover the same information as the meeting note;

   c. Paragraphs 18 to 22 deal with issues surrounding a possible IOC referral at this stage.

5. The Police have responded to my letter requesting more information/evidence and I attach their reply at flag 3. As you will see, the Police do not feel able to supply us with fuller information at present.

6. Therefore I would refer you specifically to paragraphs 21 and 18 of Toni Smerdon's memo.

7. I would be grateful if you would consider whether Dr Barton should be referred to IOC at the present time. An alternative is for the office to keep the matter under close review, continuing to liaise with the Police, and to contact the Screener again if the situation changes.

Code A

File note

2000/2047 - Dr J A Barton

Meeting with police on 30 September 2003

Present: Detective Chief Superintendent Steve Watts
Detective Constable Nigel Niven
Linda Quinn

1. I was contacted by DCS Steve Watts of Hampshire Constabulary on Monday afternoon, 29 September 2003. He said that he and a colleague wished to meet with me to give me some information about Dr Barton. We agreed to meet Tuesday morning, 30 September 2003.

2. The meeting commenced with DCS Watts outlining the background to the police investigation of the case and saying that, following the disclosure by Hampshire and Isle of Wight HA of the 1991 file of correspondence in September 2002, the police decided to investigate all the deaths on patients under Dr Barton's care at Gosport War Memorial Hospital.

3. A team of five medical experts was appointed – experts in the fields of toxicology, geriatric medicine, palliative care, general practice and nursing. The experts have now reported on the basis of whether the treatment provided to each of the 62 patients was optimal, sub-optimal, or negligent; and whether the reason for death/harm was natural causes, unclear, or unexplained by natural cause/disease.

4. The medical experts' findings are:

Optimal	25%	(approximately)
Sub-optimal but causation unclear	50%	"
Negligent, cause of death unclear	25%	"

(DCS Watts said these give grave cause for concern)

5. Matthew Lohn has been appointed by the police to run a quality control check on these findings. I understand that they will not become final conclusions until that check is complete.

6. The police will then appoint further experts to examine in detail the 25% of cases (some 15 or 16) which fall into the category of "negligent, cause of death unclear".

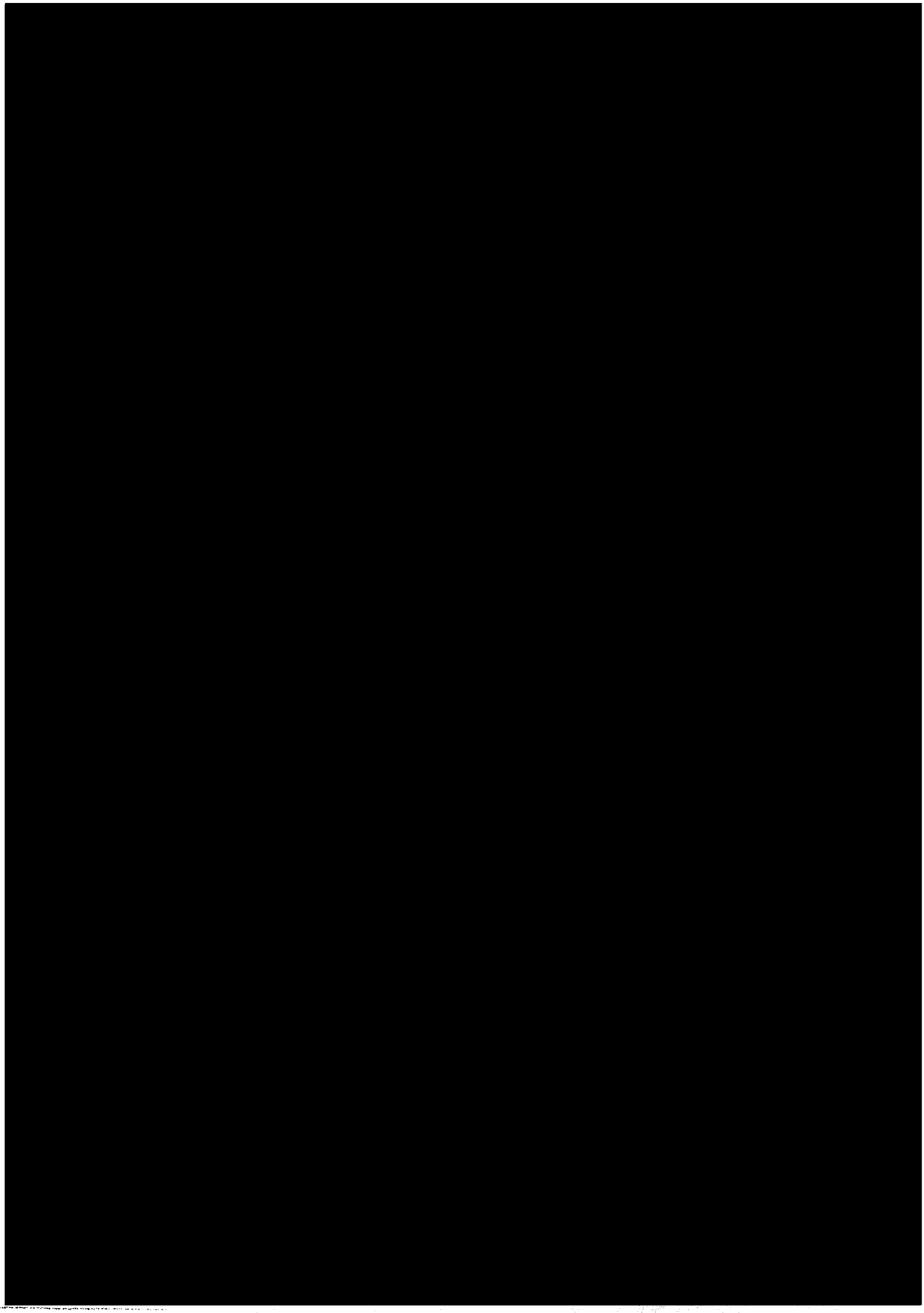
7. The police will not interview Dr Barton until the second team of experts have reported, and they expect this to be January 2004 at the earliest.

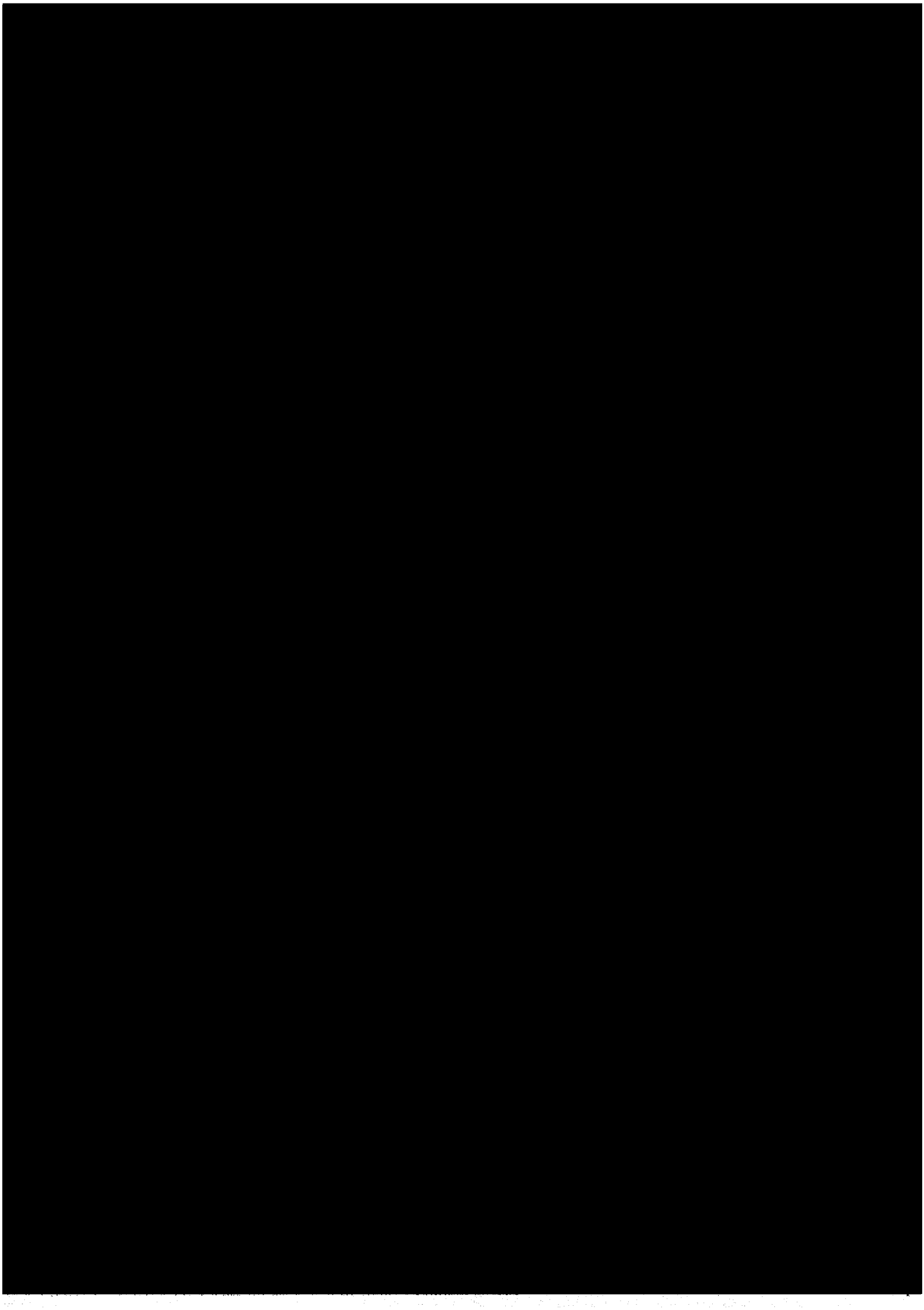
8. The police have informed Dr Barton's solicitor (Ian Barker of MDU) that they are concerned about a significant number of cases, but have not conveyed actual numbers.

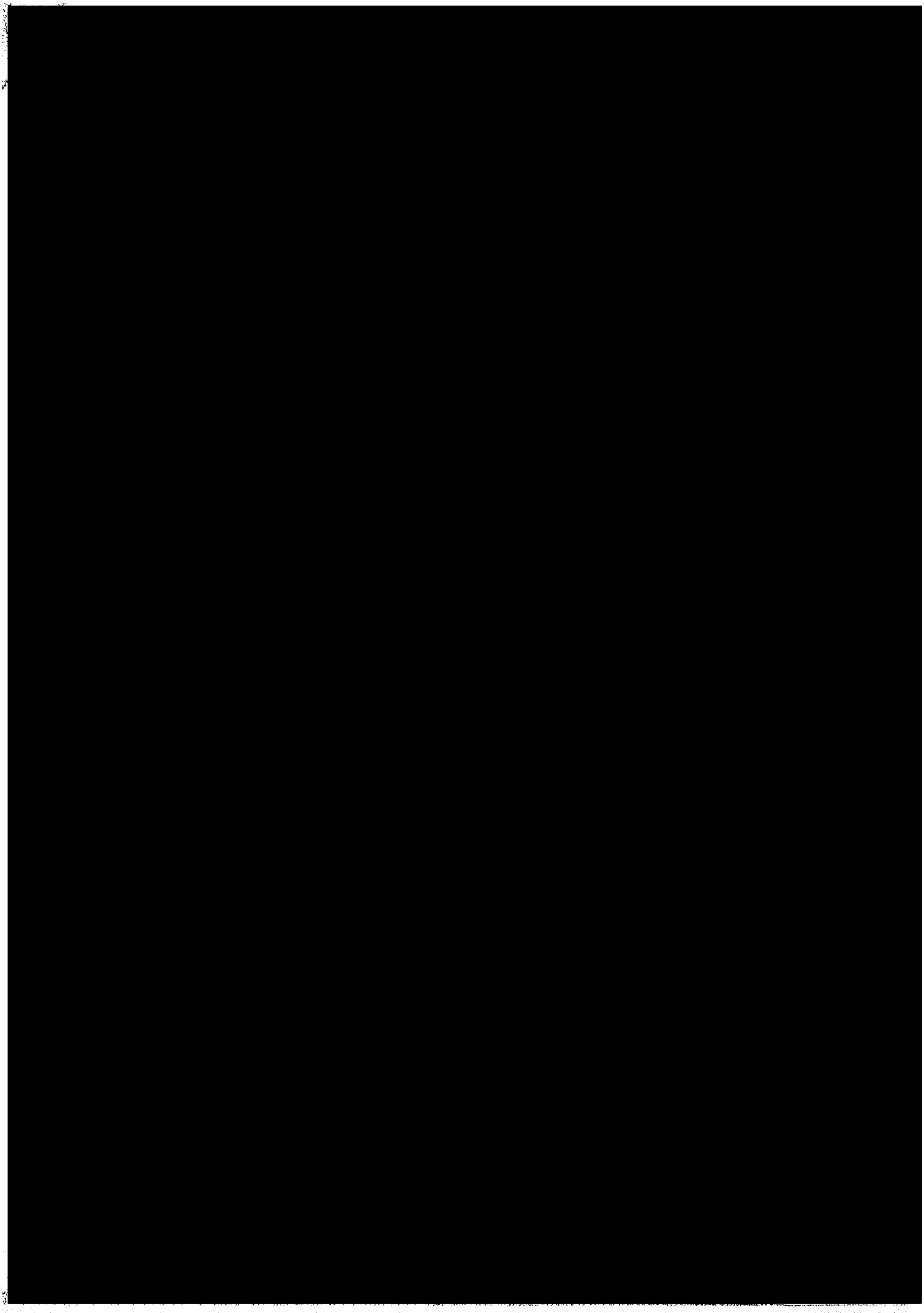
9. They also keep the families informed, through Alexander Harris, and on Friday, 3 October 2003 they are meeting with someone from the strategic health authority to update them on the investigation.

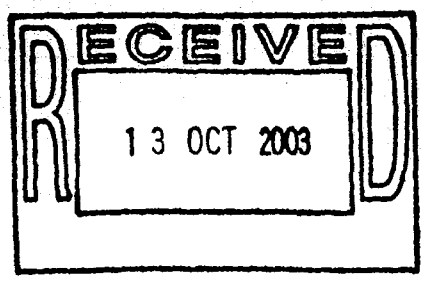
10. The police asked LQ the case would be reconsidered by the IOC on the basis of the information they were supplying. They fully understood that any papers which were to be seen by IOC would also be disclosed to Dr Barton and her solicitor. They emphasised that they were not able to provide full details of their investigations because this could jeopardise their further investigations and their eventual interview of Dr Barton. However, DCS Watts said they would be able to provide a brief written summary of the current position if we so required. We would have to request it in writing, explaining they reasons for it and why it was in the public interest for the police to supply it, and what action we envisaged taking.

Linda Quinn
30 September 2003









Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Code A

S Watts MSc DPM MIMgt
Detective Chief Superintendent
Head of CID

Your ref:

Our ref: SW/chm

6th October 2003

Ms L Quinn
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Ms Quinn

Re: **Gosport War Memorial Hospital - Operation Rochester**

Thank you for your letter dated 2 October 2003, following our meeting on 30 September 2003 regarding the above matter.

I note your comments, in particular the processes by which the GMC may consider the matter of registration.

The summary which we provided you in respect of our investigation, indicated that a team of clinical experts had examined hospital records in respect of 62 patients at Gosport War Memorial Hospital, under the care of Dr Barton. In a significant number of those cases, the experts take the view that there was negligent care and that the causation of death is unclear. As my colleague DI Niven and I explained, much further work needs to be done to validate and develop these very provisional findings. We took the view, however that the GMC and the relevant Strategic Health Authority should be appraised of this information.

As we explained to you, our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegation such those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to the public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton.

Our investigation has only considered cases up to 1998 and all relate to the treatment of patients at the Gosport War Memorial Hospital. All the cases of concern raise issues in respect of the use of opiates. My understanding at the present time is that Dr Barton is not allowed to work at the Gosport War Memorial Hospital, and is not authorized to prescribe opiates.

On the basis of the above, I think more assessment needs to be conducted to quantify and clarify the risk that Dr Barton continuing to practice currently presents to the public safety. I would emphasize that our investigation has only concerned itself with issues within the Gosport War Memorial Hospital and not in any other area of practice by any medical staff. You will be aware that Professor Richard Baker was tasked with conducting some analysis by the Chief Medical Officer. His remit would have been wider than ours and although I do not know the outcome of his research, I would imagine any conclusions he has reached might assist you in your deliberations.

It is probable that we will need to interview Dr Barton at length. The interview process is predicated upon a detailed strategy which will include a careful consideration of the information supplied to Dr Barton prior to interview. I note that your letter indicates that any information supplied to the GMC will in its totality be supplied to Dr Barton. Any uncontrolled disclosure to Dr Barton has the potential to detrimentally impact upon the investigation, and I therefore would be reluctant to disclose further information until the above issue of risk has been given thorough consideration.

If I were reassured that material would not be passed to Dr Barton or her representatives, I would be willing to consider, at a future time, providing a more detailed disclosure of information to the GMC. We would be more than happy to discuss with the GMC 'Screener' how we may best achieve the maximum disclosure without a detrimental impact upon the investigation.

Finally, in answer to your question, I can confirm that the patients that you name in the second page of your letter of 30 September were included in those reviewed by the team of clinical experts.

I look forward to hearing from you so that we may progress this matter together.

Yours sincerely

Code A

Steve Watts
Detective Chief Superintendent
Head of CID

Case 469 2000/2047 (Manchester)
Received 5.11.03. returned 6.11.03
Dr Barton vs Hampshire Constabulary

Dear Linda,

Thank you for referring this case which has already been referred to the PCC but postponed whilst the Police continue their enquiries. This doctor has already been referred to the IOC in June 2001 in respect of one case, In Feb 2002 when the CPS decided to take no action but papers were disclosed to the GMC about 4 patients who had died in Gosport Wae Memorial Hospital and in September 2002 by the president after PPC had referred to PCC but not IOC and on each occasion no order was made.

Taking into account Matthew Lohn's opinion at para 11 of Toni Smerdon's memorandum, her opinion and the lack of new evidence as the police do not want to disclose anything which may prejudice their case I do not think we should send this case to IOC again.

The doctor is not a danger to the public as she has never had any complaints about her GP work and she has voluntarily agreed to restrict her prescribing of certain drugs. She has resigned from her post at Gosport War Memorial Hospital.
If and when the police charge Dr Barton it would be reasonable to send to IOC but in the absence of new evidence I think the same advice would come from the legal assessor as before

I agree that the office should keep the matter under review and refer back if new evidence is disclosed by the police or Dr Barton is formally charged WDS 6.11.03.

Code A

no SOF4 enclosed - if you want me to begin send on its own

(Fax rec'd 7.11.03.
Copied to Jackie Smith
+ Toni Smerdon for info.
Code A
7.11.03)

Memorandum

To **FTP Screener**

From **Linda Quinn**
Conduct Case
Presentation Section
Code A

Date **27 October 2003**

Copy **Jackie Smith**

Dr J A Barton (2000/2047)

1. I write to give you an update on this case and to seek your view as to whether the matter should be submitted to IOC.

2. I attach a copy of the IOC item prepared for 19 September 2002, when the IOC determined not to make an order restricting Dr Barton's practice (flag 4).

3. I have recently met with the police who wished to provide the GMC with an update as to their investigations. My note of that meeting is at flag 1.

4. I also attach, at flag 2, a memorandum from Toni Smerdon, In-House Legal Team:

   a. Paragraphs 2 to 11 give background to the current position, including the outcome of three referrals of the matter to IOC between June 2001 and September 2002;

   b. Paragraphs 12 to 17 cover the same information as the meeting note;

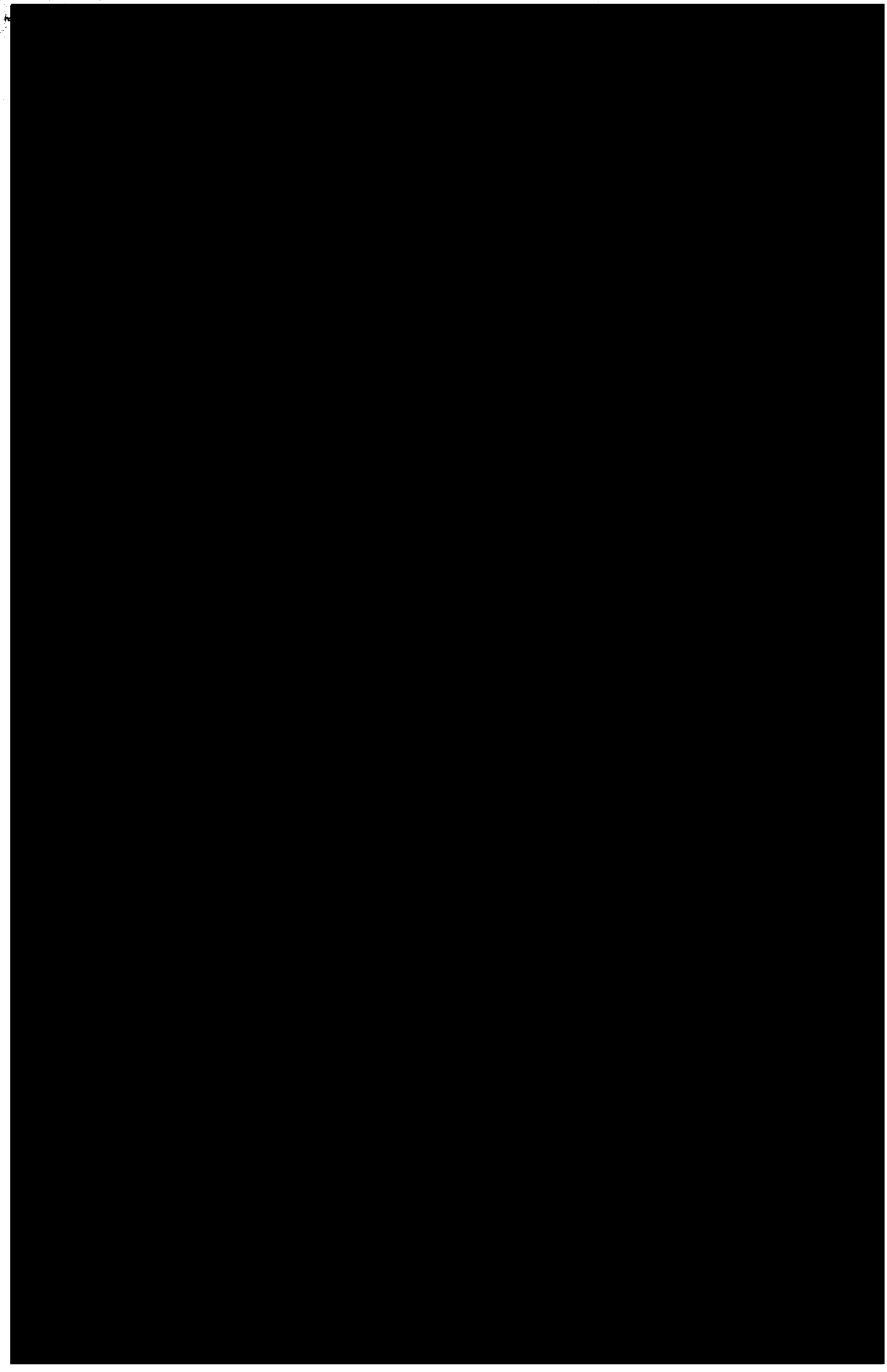
   c. Paragraphs 18 to 22 deal with issues surrounding a possible IOC referral at this stage.

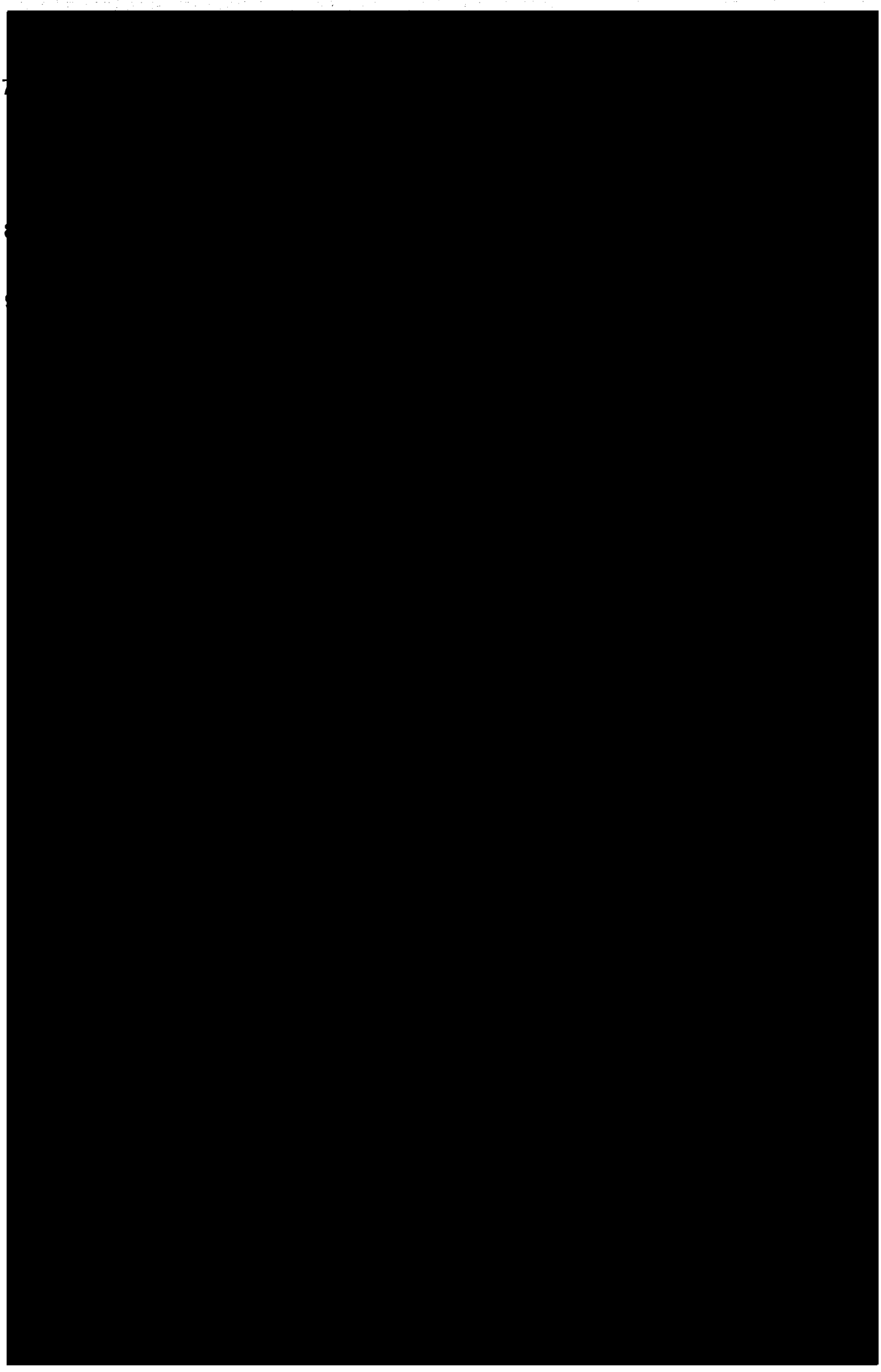
5. The Police have responded to my letter requesting more information/evidence and I attach their reply at flag 3. As you will see, the Police do not feel able to supply us with fuller information at present.

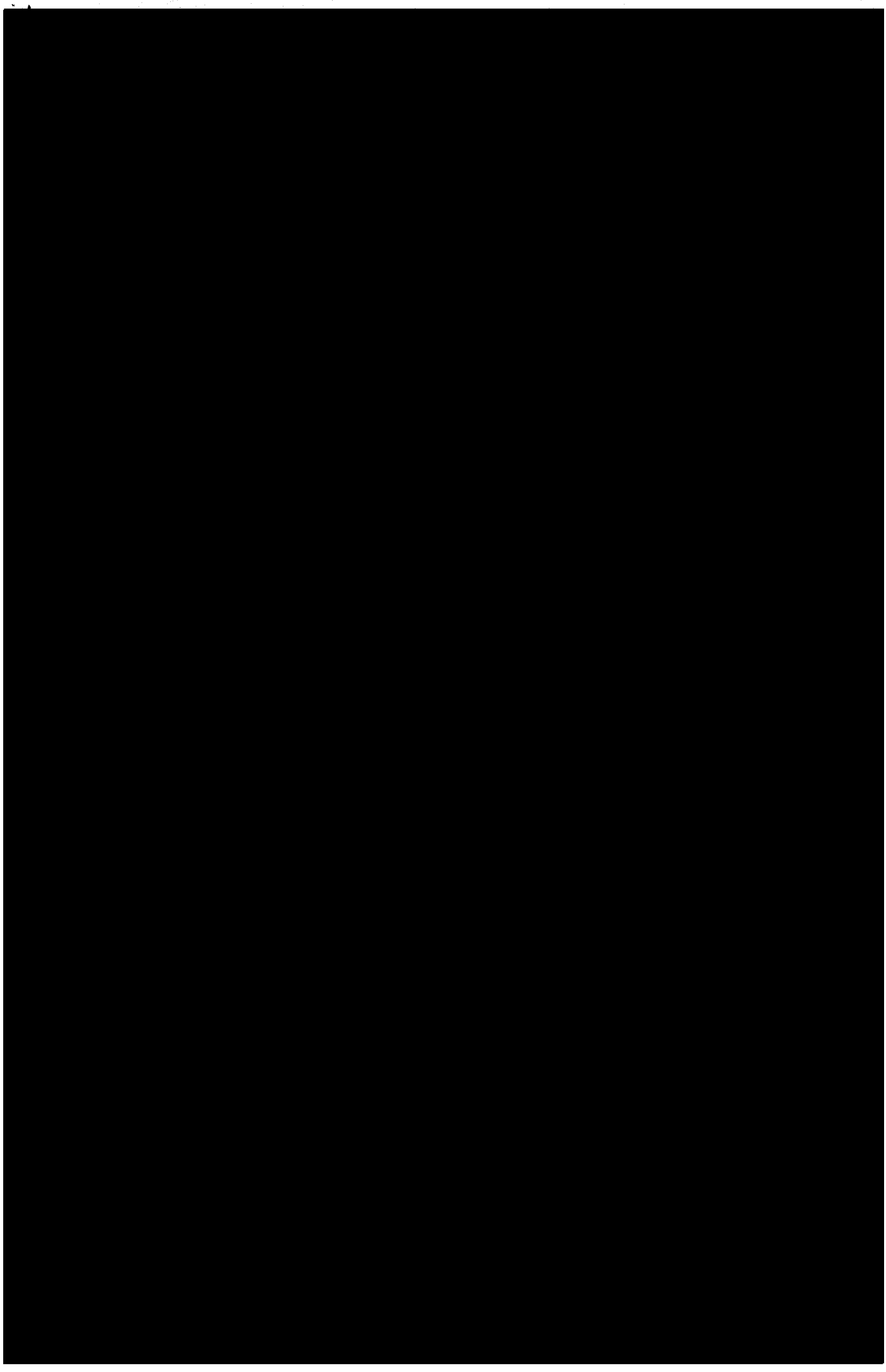
6. Therefore I would refer you specifically to paragraphs 21 and 18 of Toni Smerdon's memo.

7. I would be grateful if you would consider whether Dr Barton should be referred to IOC at the present time. An alternative is for the office to keep the matter under close review, continuing to liaise with the Police, and to contact the Screener again if the situation changes.

Code A







Memorandum

To Paul Philip

From Linda Quinn

Date 30 September 2003

Copy Jackie Smith

Dr J A Barton (2000/2047)

1. I have today met with two officers from Hampshire Constabulary who sought the meeting in order to update the GMC on the progress of their investigations.

2. I attach my note of the meeting at flag A, and for background, I attach a copy of a memo dated 13 September 2002 at flag B.

3. Consideration needs to be given to whether the information supplied by the police this morning (plus the written summary they could provide if asked) is sufficient fresh information for the matter to be referred to IOC.

4. I note from the casefile that when we initially received the 1991 information in September 2002, it was not considered sufficient to go back to IOC with (Peter Swain's email of 24 September 2002 - flag C).

5. However, the police have now had 62 cases involving Dr Barton analysed by a team of experts, and the finding in some 15 or 16 cases are "negligence, cause of death unclear".

6. As can be seen from paragraph 5 of my note, the results are to be quality checked.

7. If the case is to be reconsidered by IOC in the light of new information, it will be necessary to decide whether this should be done after the quality check on the first set of experts' findings, or whether it should be done after the second set of experts report to the police (possibly January 2004).

8. Dr Barton's case has been considered by IOC three times so far, and in each case no order was made.

9. The police are updating Alexander Harris (for the families) this afternoon, and the strategic health authority on Friday 3 October 2003. These updates may generate inquiries to the GMC.

Code A

File note

2000/2047 - Dr J A Barton

Meeting with police on 30 September 2003

Present: Detective Chief Superintendent Steve Watts
Detective Constable Nigel Niven
Linda Quinn

1. I was contacted by DCS Steve Watts of Hampshire Constabulary on Monday afternoon, 29 September 2003. He said that he and a colleague wished to meet with me to give me some information about Dr Barton. We agreed to meet Tuesday morning, 30 September 2003.

2. The meeting commenced with DCS Watts outlining the background to the police investigation of the case and saying that, following the disclosure by Hampshire and Isle of Wight HA of the 1991 file of correspondence in September 2002, the police decided to investigate all the deaths on patients under Dr Barton's care at Gosport War Memorial Hospital.

3. A team of five medical experts was appointed – experts in the fields of toxicology, geriatric medicine, palliative care, general practice and nursing. The experts have now reported on the basis of whether the treatment provided to each of the 62 patients was optimal, sub-optimal, or negligent; and whether the reason for death/harm was natural causes, unclear, or unexplained by natural cause/disease.

4. The medical experts' findings are:

Optimal	25% (approximately)	
Sub-optimal but causation unclear	50%	"
Negligent, cause of death unclear	25%	"

(DCS Watts said these give grave cause for concern)

5. Matthew Lohn has been appointed by the police to run a quality control check on these findings. I understand that they will not become final conclusions until that check is complete.

6. The police will then appoint further experts to examine in detail the 25% of cases (some 15 or 16) which fall into the category of "negligent, cause of death unclear".

7. The police will not interview Dr Barton until the second team of experts have reported, and they expect this to be January 2004 at the earliest.

8. The police have informed Dr Barton's solicitor (Ian Barker of MDU) that they are concerned about a significant number of cases, but have not conveyed actual numbers.

9. They also keep the families informed, through Alexander Harris, and on Friday, 3 October 2003 they are meeting with someone from the strategic health authority to update them on the investigation.

10. The police asked LQ the case would be reconsidered by the IOC on the basis of the information they were supplying. They fully understood that any papers which were to be seen by IOC would also be disclosed to Dr Barton and her solicitor. They emphasised that they were not able to provide full details of their investigations because this could jeopardise their further investigations and their eventual interview of Dr Barton. However, DCS Watts said they would be able to provide a brief written summary of the current position if we so required. We would have to request it in writing, explaining they reasons for it and why it was in the public interest for the police to supply it, and what action we envisaged taking.

Linda Quinn
30 September 2003

Memorandum

To **Paul Philip**

From **Venessa Carroll**
CCPS

Date **13/09/02**

Copy **Jackie Smith**
Finlay Scott
Stephanie Day
Peter Swain

Dr Jane Barton

1. At its meeting on 29 August 2002, the Preliminary Proceedings Committee referred this case for an inquiry by the Professional Conduct Committee. It has today been referred to the Interim Orders Committee for a hearing on 19 September 2002. This will be the third time that the IOC have considered the case having previously made no order. Below I have set out, under separate headings, the history of the case and what the case is about.

The history of the case

2. In July 2000, this case began as a police investigation into the circumstances surrounding the death of Gladys Richards, a geriatric patient at Gosport War Memorial Hospital (GWMH), and was subsequently extended to 4 other deaths - Arthur 'Brian' Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

3. The case was first considered by the IOC in June 2001. At that time the police investigation was at an early stage and only Gladys Richards' death was being investigated. The information before the Committee was limited and it made no order.

4. By February 2002 the police/CPS had decided against a criminal prosecution and their papers were disclosed to the Council to decide on issues of potential spm/sdp. The case was screened in ~~May~~ February 2002 (Screener: Malcolm Lewis) who referred it to the Preliminary Proceedings Committee and also referred the case back to the IOC.

5. The IOC considered the case for the second time on 21 March 2002 and again made no order.

6. On 28 May 2002, Mrs MacKenzie (daughter of the late Gladys Richards) wrote to the GMC copying the letter to David Blunkett MP, the police, Nigel Waterson MP, Peter Viggers MP, the Police Complaints Authority, the CPS and David Parry Treasury Counsel, concerned about the failures of the police investigation. I understand that it is because of Mrs MacKenzie that the police investigation has been re-opened.

13 September 2002

7. The Rule 6 letter was sent to Dr Barton on 11 July 2002 notifying her of the PPC hearing on 29-30 August 2002. The charge set out in the Rule 6 letter is set out below.

8. In July 2002, CHI published a report titled "Gosport War Memorial Hospital: Investigation into the Portsmouth Healthcare NHS Trust". The report does not name Dr Barton specifically but refers to the criminal investigations and criticises systems in place at the time.

9. On 30 July 2002 Mrs MacKenzie informed the GMC that the police were seeking advice from the CPS about the investigation. We understand the present position to be that the CPS are reconsidering the five cases.

What the case is about

10. The Charge set out in the Rule 6 letter is set out below. You will see that the case relates to Dr Barton's prescribing to five patients between the ages of 75 and 91 between February 1998 and October 1998. These patients were attending Gosport War Memorial Hospital, mainly for rehabilitation. It was Mrs Lack's concerns (who was an experienced nurse in elderly care) about the treatment of her elderly mother (Mrs Richards) in the ward, which precipitated the reviews of other patients. Dr Barton was a visiting clinical assistant who was responsible for the day-to-day management of these five cases. Dr Barton in her defence maintains that that overwork had apparently affected patient care. There have been expert reports and in his report, Professor Ford concludes that the prescribing regime was variously reckless, excessive or highly inappropriate. The view is that death appears to have been precipitated if not caused by the drug regime in each case.

In the information it is alleged that:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a.i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

13 September 2002

b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

13 September 2002

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs Wilkie's rehabilitation needs;

4. a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

13 September 2002

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Michael Keegan Code A

From: Paul Philip Code A
Sent: 24 Sep 2002 17:38
To: Peter Swain Code A Michael Keegan Code A
Subject: RE: Dr Barton

Peter,

Thanks. I suggest we go ahead as you describe. Does someone need to tell whoever gave us the papers what is happening?

Paul

-----Original Message-----
From: Peter Swain Code A
Sent: 24 Sep 2002 17:10
To: Paul Philip Code A Michael Keegan Code A
Subject: RE: Dr Barton

These papers are from 1991 and demonstrate that nursing staff raised their concerns at that time about the extent to which diamorphine was used routinely and in considerable quantity for pain relief for terminally ill patients. It is said that some terminally ill patients died as a consequence of that prescribing - though when pressed the nursing staff seemed reluctant to name individual cases. The nursing staff were supported by the RCN representative and there followed some local meetings; but the outcome appears to have been an acceptance that ultimately prescribing is for the clinical judgement of the relevant doctor.

These papers are supporting evidence for the substantive PCC case and as such they should be passed to our lawyers; but they do not provide sufficient grounds for us to invite the IOC to reconsider the case.

Peter

-----Original Message-----
From: Paul Philip Code A
Sent: 24 Sep 2002 15:46
To: Michael Keegan Code A Peter Swain Code A
Subject: RE: Dr Barton

Peter,

Can you have a look at these please.

Paul

-----Original Message-----
From: Michael Keegan Code A
Sent: 23 Sep 2002 14:01
To: Paul Philip Code A; Peter Swain Code A
Subject: Dr Barton

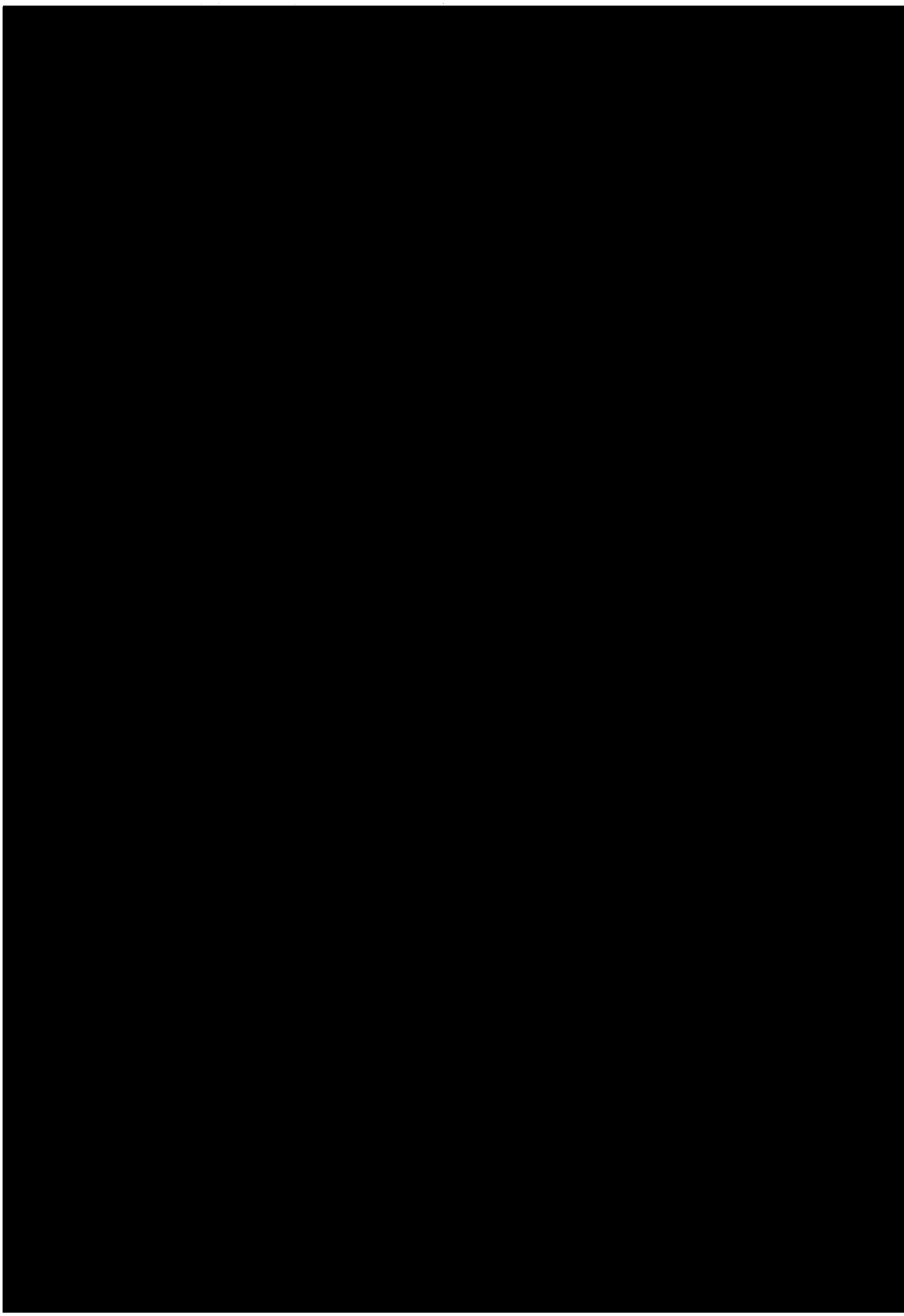
We have now received from Dr Simon Tanner, Director of Public Health at Hampshire and Isle of White Health Authority, a small file of correspondence, which was passed to the management of Fareham and Gosport Primary Care Trust by a member of staff on 16/9/02.

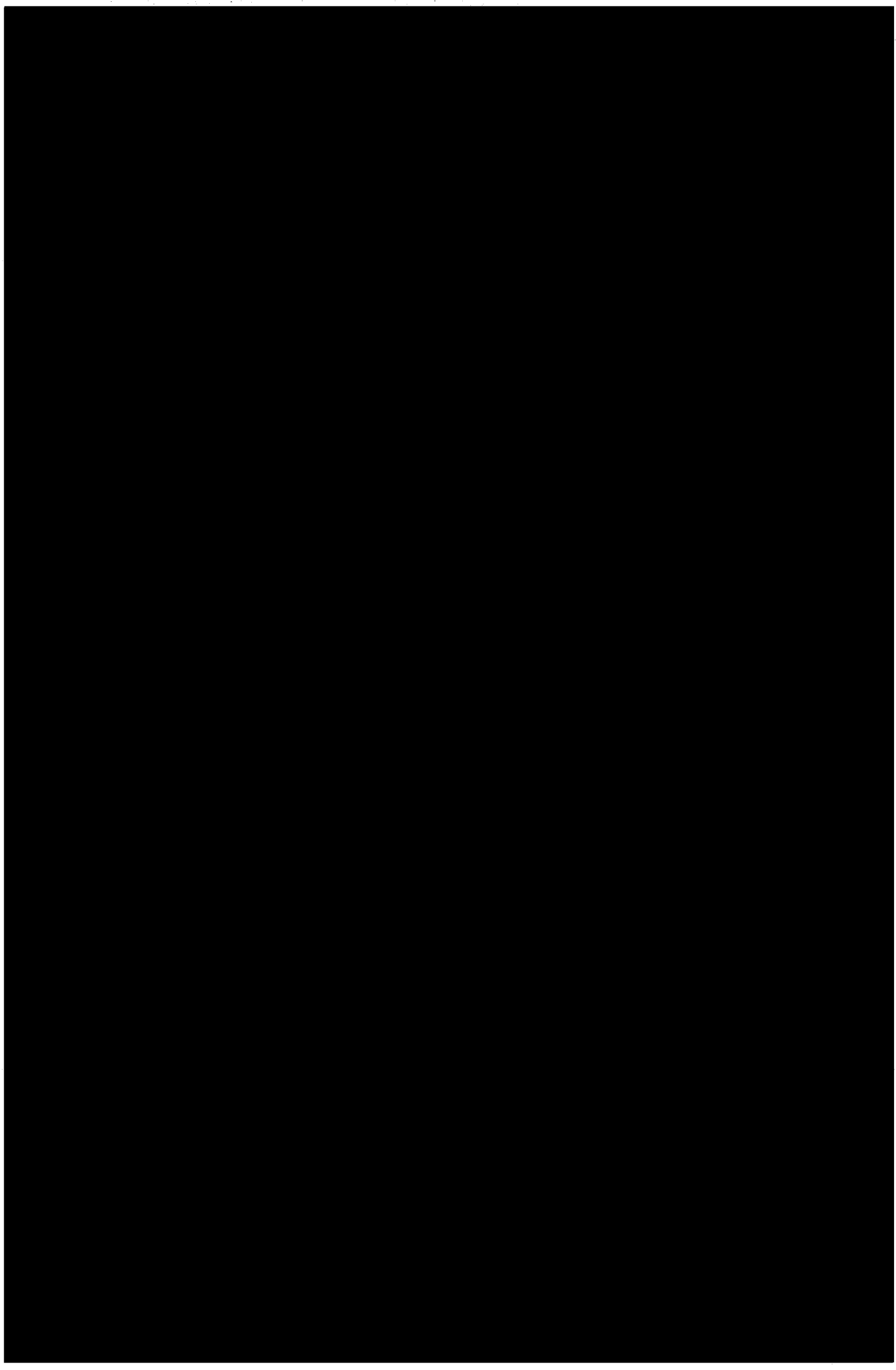
It includes copies of correspondence from the RCN Branch Convenor to various persons at the Trust and minutes and memoranda regarding meetings held with nursing staff to discuss their concerns about use of diamorphine in the unit.

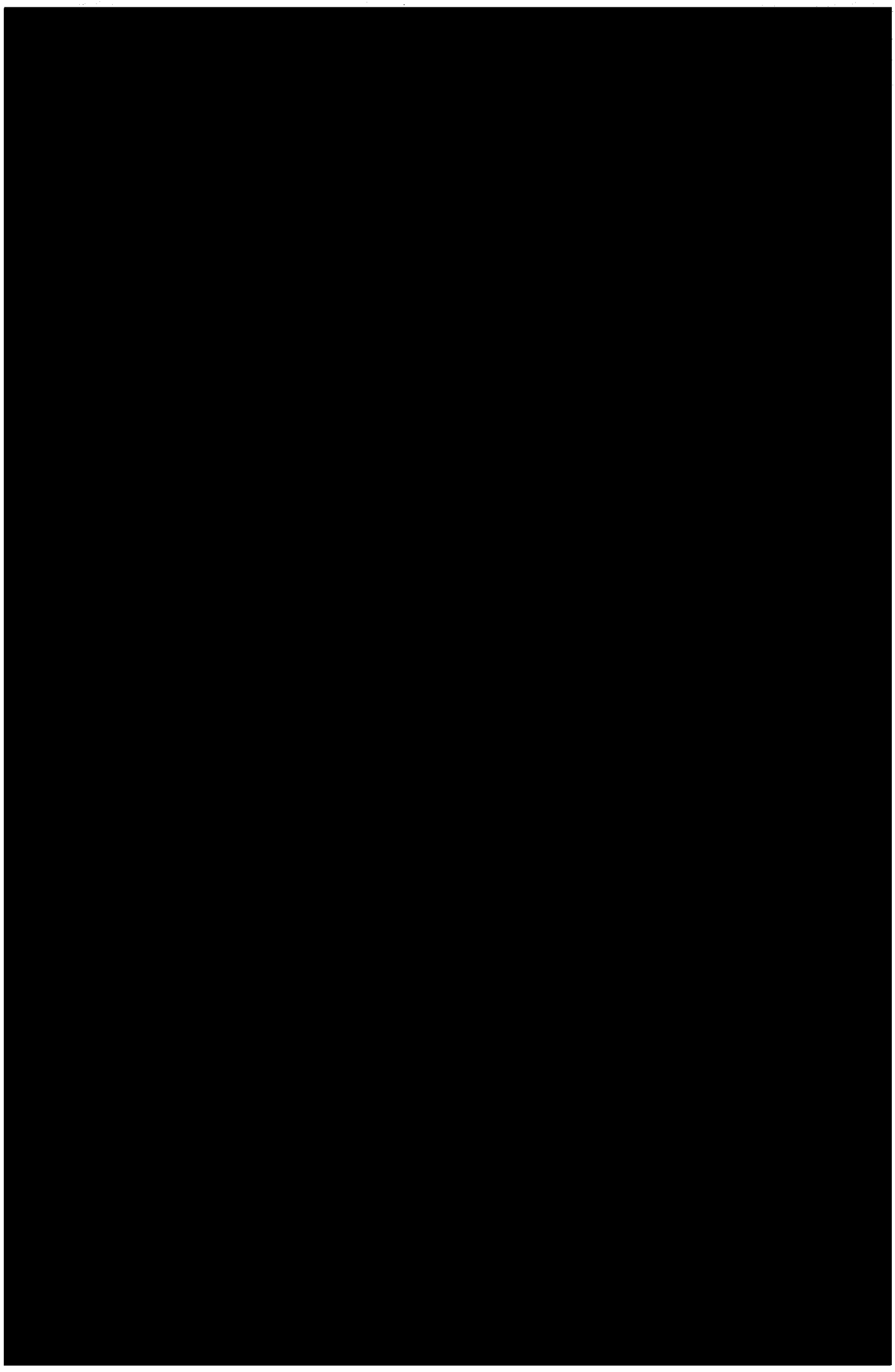
I will provide copies of the same if you wish.

Michael.

[redacted]







[redacted]

[redacted]

File Note
Dr J A Barton
2000/2047

Dr Barton is a GP who held a part-time clinical assistant role in elderly medicine at Gosport War Memorial Hospital (Daedalus and Dryad wards). The Hampshire Constabulary originally referred the information for this case.

The allegations concern high levels of opiate and sedative drugs prescribed and administered to elderly patients, often by syringe driver, most of whom were admitted for rehabilitative and not palliative care.

The Screener had already closed complaints about Dr Barton, failures of communication at the hospital and other matters from relatives, following local / Health Service Ombudsman's reviews with independent medical advise that raised no concerns, as follows:

Case Number	Patient	Relative
2000/0247/03	Mrs Purnell	Mike Wilson
2002/0553	Elsie Devine	Code A
2002/1345	Stanley Carby	Mrs R E Carby

2002/1608 This arose from the CHI report about the treatment of elderly patients between 1998 and 2001, which makes reference to 10 complaints to the Trust (which are either known or not of concern to us).

PPC considered matter on 29/08/2002 in relation to the following patients, whose names are shown alongside relatives with whom we have been in contact:

Patient	Relative
Eva Page	Bernard Page
Alice Wilkie	Code A
Gladys Richards	Gillian McKenzie
Arthur Cunningham	Charles Farthing
Robert Wilson	Iain Wilson

(FFW have been asked to advise on including the case of Mr Carby under Rule 11.)

Screening closed a case concerning patient Dulcie Middleton made by Marjorie Bulbeck.

IOC considered the case on 21 March 2002 and made no order.

Mike Gill, Regional Director of Public Health, took an early interest (as did the CMO) and suggested that the IOC reconsider the matter. The President subsequently referred the case to IOC, which considered it on 19/09/2002, but again made no order on the basis that no new material had come to light since its earlier decision. Simon Tanner of the Isle of White Health Authority then submitted a 'dossier' containing information about concerns raised by nursing staff about prescribing practices in the early 1990's that had, apparently, not been acted upon in any substantive way. Consideration was given to reverting to IOC but it was decided that they did not provide sufficient grounds for such a course (a view subsequently endorsed by Matthew Lohn at FFW).

The CMO commissioned a clinical audit of the hospital to be undertaken by Prof Richard Baker. Police indicated that this was not likely to be concluded in the near future.

Police inquiries, based on one case (Gladys Richards), were closed but then reopened, with an increasingly wide scope of inquiry with the backing of CPS counsel. Initially an additional four cases were considered and, in conjunction with Baker's audit, a larger number of deaths has, and is, being investigated. DCS Watts was appointed the Senior Investigating Officer following some criticism of the earlier SIO. FFW and I have had meetings with DI Nigel Niven and DS Owen Kenny.

A police investigation remains open and, hence, our inquiries are in limbo.

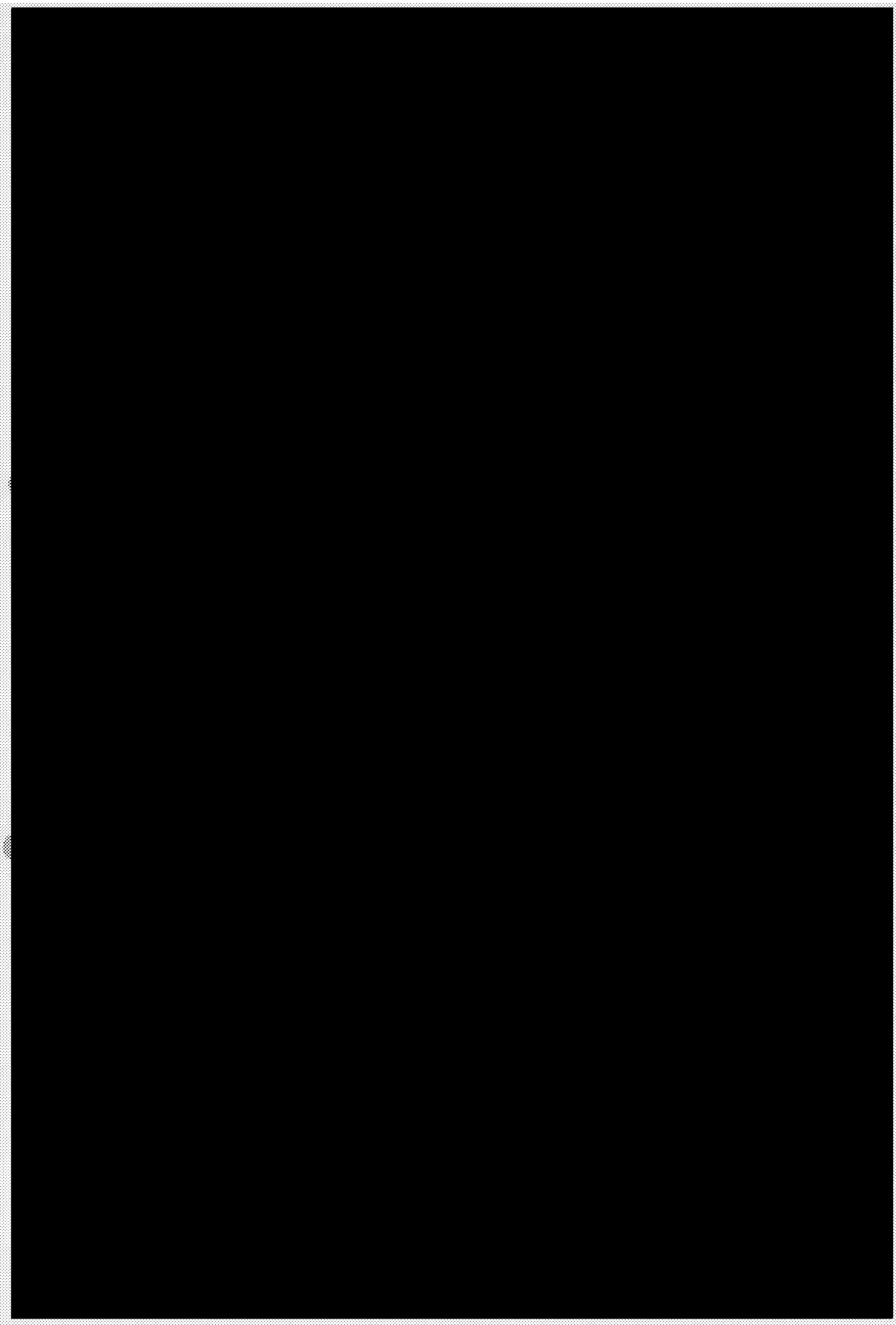
Judith Chrystie at FFW is dealing and has visited CHI, who conducted a review of the hospital, to obtain records of interviews, etc. that might be of use when we can progress our investigation (in the event that the police investigation does not result in a conviction).

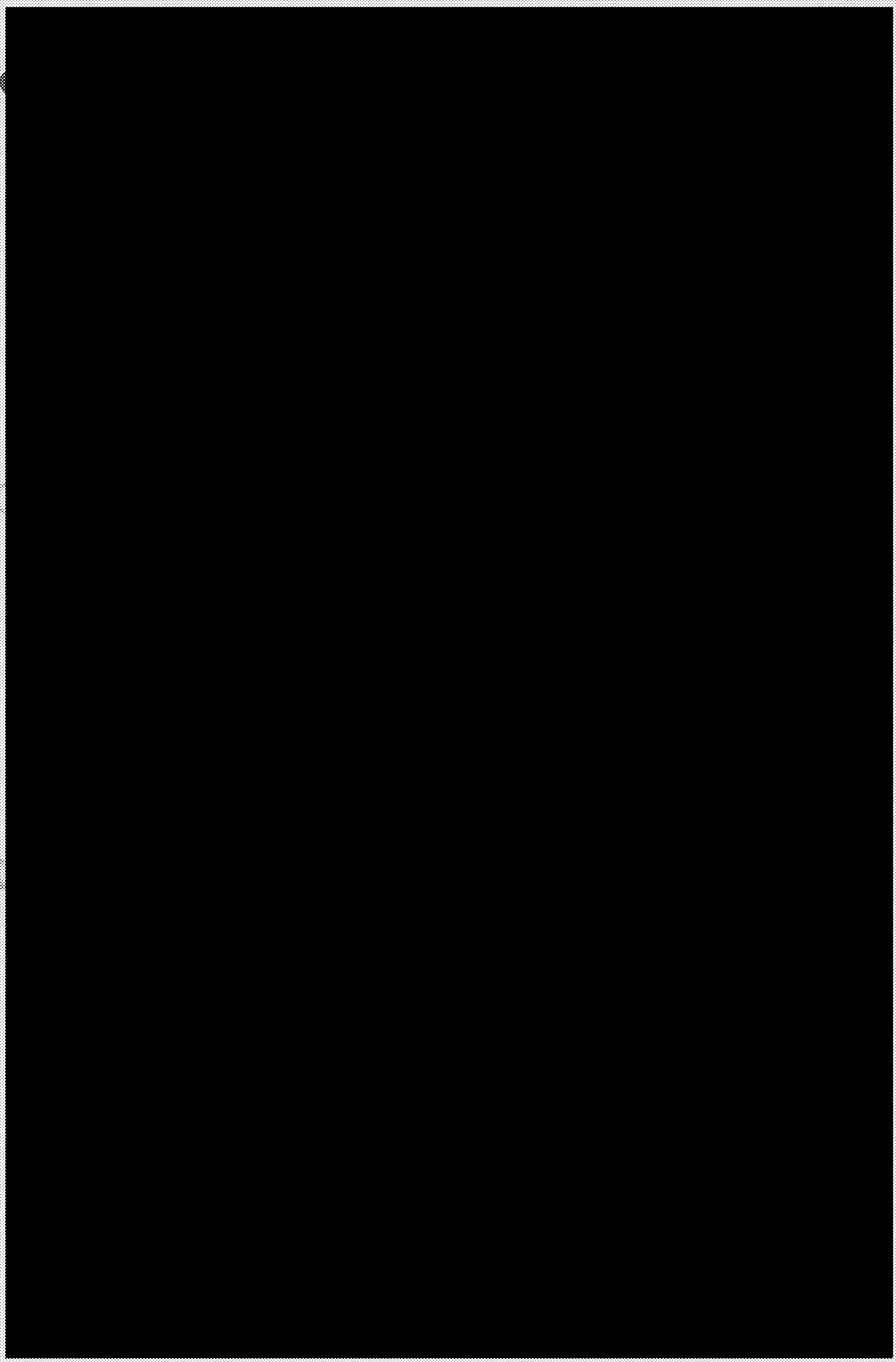
All of the relatives of patients whose cases we are progressing are now represented by Messrs Alexander Harris. A number of the relatives were concerned that any GMC inquiry could potentially adversely effect on a criminal prosecution. I reassured them and then Alexander Harris that we had no intention of holding our inquiry until the criminal investigation had finished. Alexander Harris queried why we are dealing with this as an information case when the original concern was raised by relatives. I responded on 18/12/2002 that the information for this particular case (2002/2047) came from the Hampshire Constabulary.

The Police requested from FFW a number of documents, including a copy of the last IOC transcript, in which is recorded Dr Barton's explanation of events. I asked FFW to ask the Police to make their request formally so that consideration could be given to that at a senior level. The Police, in turn, asked FFW to formally request that ! Police have also formally requested that we stay proceedings until the resolution of the criminal investigation.

This case had been listed for PCC on 07/04/2003 but then removed from the list for the above reasons. If and when it is ready to be heard an initial pro-forma should be submitted.

Code A 4/03





[redacted]

Michael Keegan Code A

From: Michael Keegan Code A
Sent: 19 Dec 2002 13:09
To: Michael Keegan Code A
Subject: FW: Dr J A Barton

I spoke to Gill and agreed that, as this case was unlikely to be ready for hearing (following police inquiry) for (potentially) years, it was better to take it out of lists and, when ready, submit an initial pro forma.

Michael Keegan
19/12/2002

-----Original Message-----
From: PCC Lists (Committee)
Sent: 19 Dec 2002 13:06
To: Michael Keegan Code A
Cc: PCC Lists (Committee)
Subject: RE: Dr J A Barton

Hi,

just to confirm I have removed this case from the list.

Thanks

Gill

-----Original Message-----
From: Christopher Antill (7915 3414)
Sent: 18 Dec 2002 11:01
To: Code A PCC Lists (Committee); Code A
Code A
Subject: FW: Dr J A Barton

From: GMCWEB@GMC-UK.ORG[SMTP:GMCWEB@GMC-UK.ORG]
Sent: Wednesday, December 18, 2002 10:59:52 AM
To: Code A
Subject: Dr J A Barton
Auto forwarded by a Rule

FPD_Case_Ref: 2000/2047
Caseworker: Michael Keegan
Doctor_Name: Dr J A Barton
Provisional_Listing_Date: 7 April 2003
Current_Employer: Hampshire & Isle of White Health Authority
Duration: 15 days
Location_Practise: Hampshire
Council_S_Firm: Field Fisher Waterhouse
Council_S_Name: Judith Christie
Council_S_Reference:
Defence_S_Firm: MDU
Defence_S_Name: Ian Barker
Defence_S_Reference:
Defence_S_Add_Info:

Amber:
Submit_B: Submit
Remote Name: 100.10.2.19
Remote User: GMC_HQ\mkeegan

Correspondence_Add

see IRS

New_IOC_Hearings

Other_Changes

Please adjourn sine die. Police investigations are ongoing and will not be complete in time for PCC to consider matters in April 2003.

Case_Summary

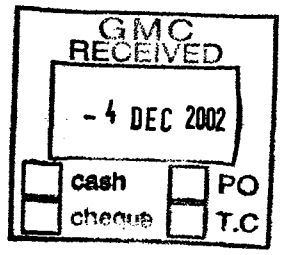
Inapropriate / irresponsible prescribing.

M KERRIGAN.

Date: 3 December 2002
Your Ref: SJ436498932GB
Our Ref: 1-153632335

The Real Network
Customer Service Centre
Clippers House
PO Box 740
SALFORD
M50 3YY
Telephone 08457 740 740
Website www.royalmail.com
Textphone 08456 000 606
(for the deaf and hard of hearing)

Code A
GMC
178-202 Great Portland Street
LONDON
W1W 5JE



Dear Code A

Thank you for your enquiry received on 18th September about a Special Delivery item of mail, reference SJ436498932GB, posted to:

J A Barton
Code A

I can confirm that this item was delivered to that address on 13th September 2002 and a photocopy of the signature we obtained is enclosed.

If we can be of any further assistance, please do not hesitate to contact us on 08457 740 740.

Postwatch, the independent consumer body for postal services, exists to represent customers' interests. If you would like further information, they can be contacted on 08456 013 265 or at Freepost Postwatch.

Yours sincerely

Code A
Julie Lyons
Customer Service Advisor

Enclosures : copy of signature

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		Priority 2	Recorded 2	Pouched off

RB 5209 5089 7GB SIGNED FOR — Time 1 0920

SQ 0765 1479 8GB 12.00pm sign — Time 2 1010

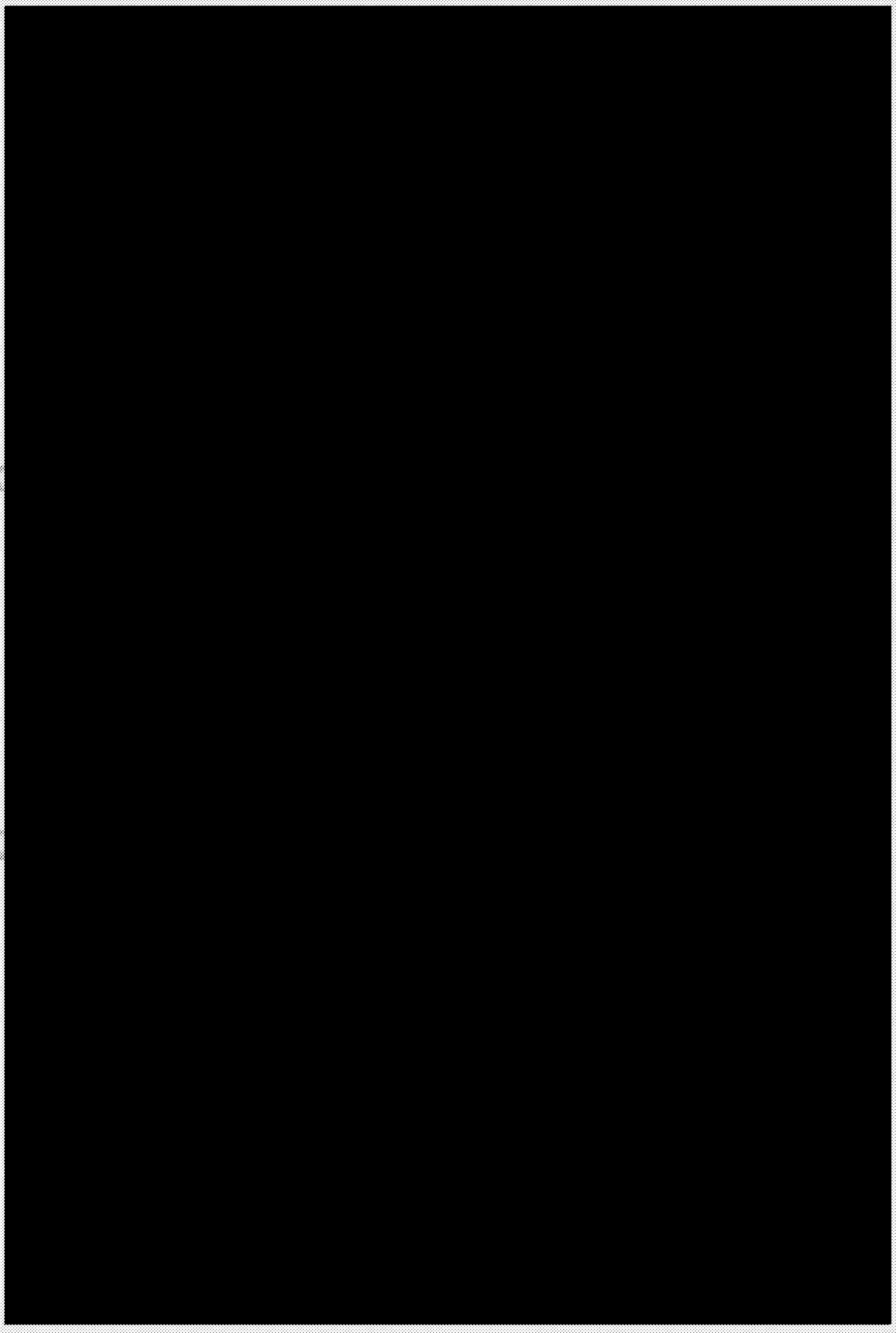
RB 5209 5505 GB SIGNED FOR — Time 3 1040

SJ 330 393 2GB 12.00pm sign — Time 4 1050

Retain for one year

Version 2 July 01 P4550 Revised October 98 N 496024

Code A



DR. BARTON

ROUGH NOTE OF MTG. WITH FFW + POLICE 20.11.02 ... JUDITH TO ~~PROVIDE (AGREED?) NOTE~~ ?

PATIENT	RELATIVE	
Stanley Carby	Mrs R F Carby	Incl. under Rule 11 ?
Eva Page	Mr B. Page	
Alice Willie (complaint ?)	Mrs M Jackson X → Code A	Code A
Gladys Richards	William McKenzie + Lesley Lack	Initial Police complaint
Arthur Cunningham	Mr CRS Farthing (?)	
Robert Wilson	Mr I Wilson	
(?) Mrs ~~Gilbertson~~ Barton ?		Incl. under Rule 11 ?

POLICE:

Nurses' + families' statements

(NFA until CPS "final" decision ?!)

→ Are Police investigations actively ongoing? When likely to concl.?

Alexander Solicitors – act for Ann Reeves + 18 x families

↓

Closed @ Screening

Hampshire Constabulary

Mrs Richards complaint → CPS

↓

10/8/01: Insufficient evidence

↓

DS T. James accepted that advice

↓

Prelim: enquiries re: other deaths ← (random) Expert report re: 4 x patients + ~~incl~~ Richards

↓

NFA (Psych) A subject to substantial new evidence

BUT raises concerns re: prof. conduct

CH1 ← what info. / doc's ?

Staff concerns raised in 1991 ? Relevant to these 5 -> cases ?

Sally Smith QC ?
medical ethics exp.

DI Nigel Niven (St George's Hospital)

DS Owen Kinney

wed 8/1/03 – mtg. ć FFW : CONFIRM
FFW to visit CHH to see their doc's
– what's relevant ? – statements

Conviction or spec route @ PCC ?
← depends on police

~~Additional~~

Prof. Barker study – long time !

Prof. Robert Forrest approached by police to report on 5 x cases referred.

? review of 50+ / 500+ cases ? To be decided upon
→ potentially protracted ... 1/2 years.

time
police = seeing close (c/s) on 28/11 ... Confirmation of course of inquiries will follow in writing.

?
what has Barton seen ? ... 3 x reports.

20/11/02

IOC — Return to IOE with Police ref. to more cases (+ pass extra expert reports).

What the minimum amt. of evidence IOC needs?... ① to refer back, or ② make an order.

CHI — Police agreed to FFW reviewing CHI docs.

Barton's CV — Barton's CV? / Qualifications? ?

Barton ✓ Lord ✗ others ? = Napuzzen (?) = ? = ?

Id'ed in (50) strs complaints

Only one id'ed as inappropriately prescribing diamorphine by syringe driver.

Ann Alexander (50's): we can say that monthly liaison between Police & GMC (FFW) is ongoing.

Police have agreed that AA = contact point with families

"whilst independent + with different agendas, Police + GMC are communicating"

10c transcript - disclosure to police

1

crime under investigation ?

TELEPHONE MESSAGE PAD Code A

FROM Julie Miller (CHI)

TO Michael Keegan

TIME/DATE 8.11.02

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

RE: Dr BARTON

Re: my letter of 4.10.02 – asked what docs we really want (I explained that I hadn't realized how much there was)... Gve would like to speak to those (e.g. family members) who gave interviews before releasing records of the same to us.

I said I would speak to J. Christie @ PPW & revert to CHI with detailed request.

Message taken by... Code A

FILE NOTE

15/10/2002

RE: DR BARTON

I spoke to Judith Christie 15 October 2002.

I acknowledged receipt of Matthew Lohn's letter re IOC.

I advised that I had asked for PCC dated to be changed to 7 April.

She said she would review CHI report and then we could discuss that documents we really wanted.

She said that she had had difficulty in setting up meeting with police, but would carry on trying and let me know. I told her my current dates to avoid.

She will also look at the papers for the two new files and we can discuss their possible inclusion under Rule 11(2).

Michael Keegan
15 October 2002

Form Confirmation

Thank you for submitting the following information:

FPD_Case_Ref: 2000/2047
Caseworker: Michael Keegan
Doctor_Name: BARTON, Jane Ann
Provisional_Listing_Date: 17 March 2003
Current_Employer:
Duration: 15 days
Location_Practise: Hampshire
Council_S_Firm: FFW
Council_S_Name: Judith Christie
Council_S_Reference:
Defence_S_Firm: MDU
Defence_S_Name: Ian Barker
Defence_S_Reference:
Defence_S_Add_Info:
Amber:
Submit_B: Submit

Correspondence_Add

see IRS

New_IOC_Hearings

Other_Changes

Please relist for 15 days beginning 7 April 2003.

Case_Summary

inappropriate/irresponsible prescribing

Return to the form.

Michael Keegan Code A

From: PCC Lists (Committee)
Sent: 07 Oct 2002 12:05
To: Michael Keegan Code A
Cc: PCC Lists (Committee)
Subject: RE: BARTON, Jane Ann

Michael,

I have listed this case for 17 March with the location preference as London.

Hope that is OK

Thanks

Gill

-----Original Message-----
From: Christopher Antill (7915 3414)
Sent: 04 Oct 2002 12:05

Code A

Subject: FW: BARTON, Jane Ann

From: GMCWEB@GMC-UK.ORG[SMTP:GMCWEB@GMC-UK.ORG]
Sent: Friday, October 04, 2002 11:04:12 AM
To: Code A
Subject: BARTON, Jane Ann
Auto forwarded by a Rule

Doctor_Name: BARTON, Jane Ann
REGNO: 1587920
FPD_Case_Ref: 2000/2047
Mult_Doctor_Case:
Mult_Doc_REGNOs:
Caseworker: Michael Keegan
Field_of_Practise: General Practice
Employer: Hampshire and Isle of Wight Practitioner and Patient Services Agency
Specialty: General Practice
Location_of_Events: Gosport, Hampshire
Provisional_Listing_Date:
Is_Doc_Practicing: YES
Duration: 15 days
Date_PPC_Hearing: 29 August 2002
Dates_to_Avoid:
IOC_Hearing_Date: 21 June 2001, 21 March 2002, 19 September 2002
Case_Type: Conduct
Case_Source: Information

Doctor_previously_appeared:
Previous_PCC_Appearance:
High_Profile: YES
Council_S_Firm: FFW
Council_S_Name: Judith Christie
Council_S_Reference:
Council_S_Phone:
Defence_S_Firm: MDU
Defence_S_Name: Ian Barker
Defence_S_Reference:
Defence_S_Phone: 020 7202 1500
Defence_S_Add_Info:
Screeners: Dr Lewis
Submit_B: Submit
Remote User: GMC_HQ\mkeegan

Correspondence_Add

see IRS

Location_of_Practise

Hampshire

Members_Interests

Mr Bob Nicholls, Professor Roger Green, Dr Richard Kennedy, Sir Roddy MacSween and Professor Nigel Stott, Dr Sheila Mann

Other_Comments

Please list for 17 March 2003 onwards or as soon as possible thereafter.

Memorandum

Ref:	**2000/2047**
To:	**Venessa Carrol** **Michael Keegan**
From:	**Michael Hudspith** **Code A**
Copy:	**Peter Swain**
Date:	**3 October 2002**

Out	Back

Dr Jane Barton (1587920)

Peter/Venessa - we spoke and agreed that I would provide a summary of all the 'Barton-related' issues that screening is aware of but which did not feature in the recent PPC item papers.

The PPC considered charges against Dr Barton based on her management of 5 elderly patients (Eva Page, Alice Wilkie, Gladys Richards, Arthur Cunningham and Robert Wilson) on Daedalus/Dryad Wards at Gosport War Memorial Hospital between February and October 1998. These cases were referred to the GMC by Hampshire Constabulary with each case study being supported by an independent expert opinion(s) critical of Dr Barton .

In addition to the 5 'police' cases, the following information was or has also been brought to our attention:

1. **(2000/0247/03)** - In **(date)** Mr Mike Wilson wrote to the GMC about the death of his mother, Mrs Purnell, who died on Dryad Ward on **(date)** following her transfer to the Gosport War Memorial Hospital for rehabilitation.

   Mr Wilson's complaint concerns failures in communication by hospital staff and as well as his mother's clinical car, particularly relating to prescribing. Although specifically naming Dr Barton in his complaint, the available records appeared to show that Dr Barton was only one of a number of doctors who reviewed and prescribed for Mrs Purnell. Unfortunately only limited records are available as a section of the records were erroneously destroyed by the Trust during microfilming in April 1999.

   By the time Mr Wilson wrote to the GMC Mrs Purnell's care had already been reviewed both locally and by the Health Service Ombudsman. Both reviews sought independent medical advice and both considered Mrs Purnell's treatment to have been acceptable in the circumstances. On the information available, the screeners considered that the complaint raised no issue of spm on the part of Dr Barton.

2. **(2002/0553)** - In February Code A wrote to the GMC about the death of her mother, Elsie Devine, who died on Dryad Ward in November 1999 a few weeks after being admitted for respite care.

Whilst specifically naming Dr Barton in her complaint, Code A complains of failures in communication by hospital staff as well as her mother's clinical care. By the time Code A wrote to the GMC Mrs Devine's care had already been reviewed both locally and by the Health Service Ombudsman. Both reviews sought independent medical advice and both considered Mrs Devine's clinical treatment to have been acceptable in the circumstances. On the information available, the screeners considered that the complaint raised no issue of spm on the part of Dr Barton.

I should add that Code A is currently seeking legal advice with a view to a possible civil claim. Her solicitors have requested that should we need to contact Code A we do it through them:

Alexander Harris Solicitors (contact Lisa Elkin), Ashleigh House, Ashleigh Road, Altrincham, Cheshire WA14 2DW

3. **(2002/1345)** - In June 2002 Mrs R E Carby wrote to the GMC concerning the death of her husband, Stanley Carby, who died on Daedalus Ward in April 1999 shortly after being admitted for 'rehabilitation'. After her husband's death Mrs Carby met with representatives of the Trust to discuss her concerns but was not satisfied with their responses.

Whilst specifically naming Dr Barton in her complaint Mrs Carby writes mainly of inconsistencies or inaccuracies in her husband's medical and nursing records and failure's in communication by hospital staff. Of perhaps more concern to the GMC would be the wide range of drugs written up for this patient by Dr Barton shortly after his admission and whether the manner of her prescribing was in any way inappropriate of irresponsible.

In order to properly assess whether this case raises any issues of spm against Dr Barton (or any other doctor) I would suggest we would need to obtain an expert opinion.

4. **(2002/1608)** - In July 2002 CHI published their report into the treatment of elderly patients at the Gosport War Memorial Hospital between 1998 and 2001. Whilst the report criticised a failure of Trust systems to ensure good quality patient care during this period, the Report does not apportion blame to specific individuals or mention them by name.

However, page 5 of the report makes reference to 10 complaints made to the Trust since 1998. We requested details of these complaints and

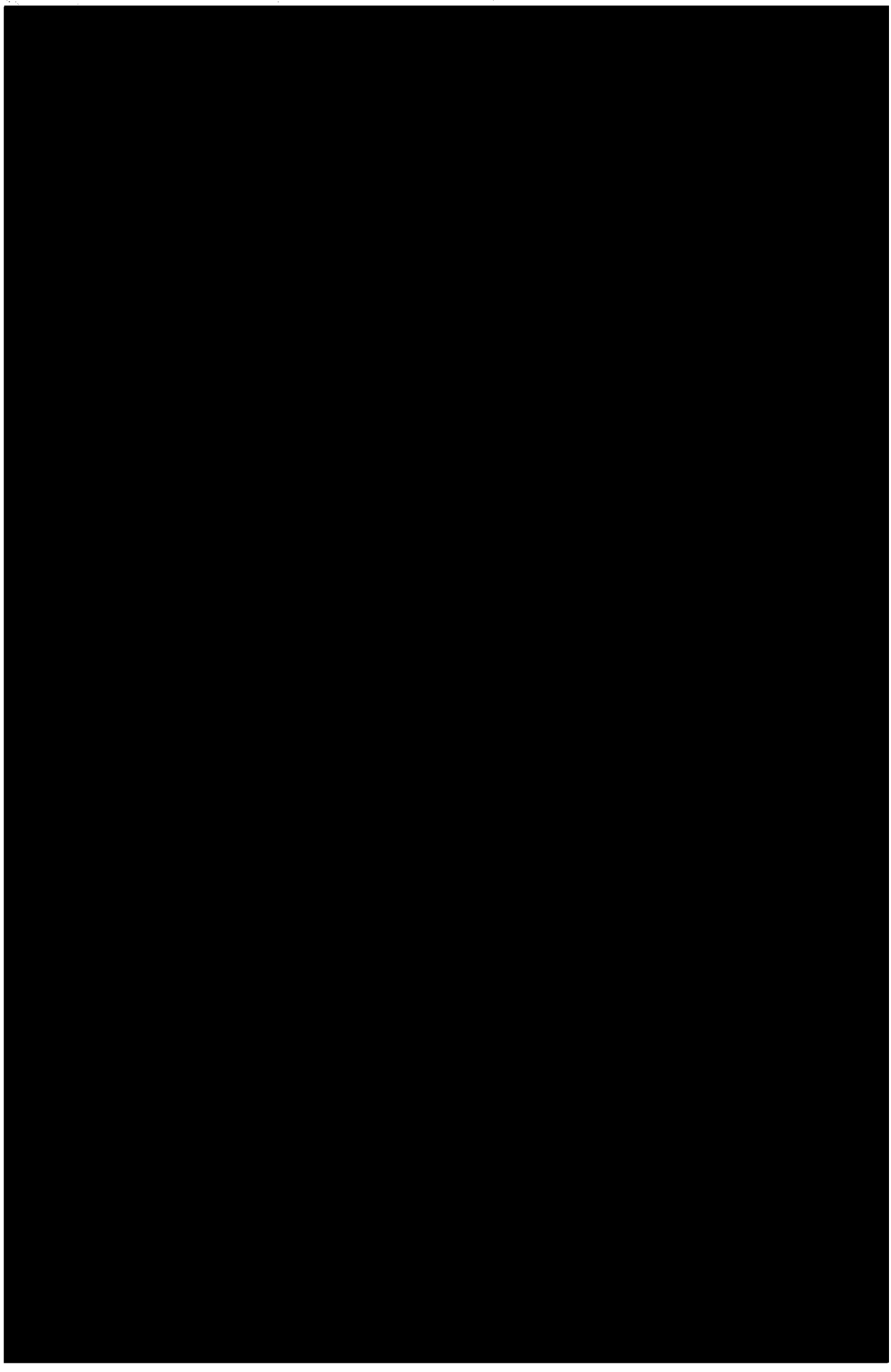
discovered that the majority were either made but individuals who subsequently wrote to the GMC or were about matters not related to our case. Only one complaint, made by a Mrs Batson in 2000 concerning the death of her mother, Mrs Gilbertson, on Dryad Ward in December 1999, appeared relevant and we recently requested and received further details. Whilst the complaint raises a number of different issues, Mrs Batson does raise the issue of pain relief (oral morphine) and mentions Dr Barton by name.

It would appear however that Mrs Batson was satisfied by the response of the Trust to her complaint and chose not to pursue the matter further.

Matters 1 and 2 are brought to your attention for background information only. With regard to matters 3 and 4 I understand that it may be open to us to consider adding these cases under Rule 11 to those matters already referred up by the PPC?

Should you have further any questions concerning any of the above, please don't hesitate to contact me.

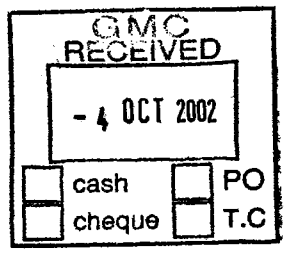
Code A



M KEEGAN.

03 October 2002

1-162262995



Code A
G M C
178-202 Great Portland Street
LONDON
W1W 5JE

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Dear Sir/Madam

Thank you for your enquiry of 30 September 2002 about a Special Delivery item number SJ436499178GB, posted to J A Barton, Code A

I can confirm that this item was delivered to that address on 14/09/2002 and a photocopy of the signature we obtained is enclosed.

If we can be of any further assistance, please do not hesitate to contact us on 08457 740 740.

Yours sincerely

Code A

Julie Lyons
Customer Service Advisor

Enclosures: Copy Of Signature

To ensure that we maintain the highest possible standards the service we provide to you is monitored on our behalf by a research agency. Each month telephone interviews are conducted with a sample of the customers with whom we have been in contact. If you would prefer not to be contacted please call Freephone 0800 652 5900 within 7 days of the date of this letter and quote the reference above.

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14/9

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PHG initials

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0131		4			

SJ 4364 9917 8GB 12.00pm sign

Time 1 Print name BARTON

Check **Code A**

SJ 1243 4192 5GB Time 2 Print name

SJ 2840 8750 3GB Time 3

Code A

SJ 2092 5989 2GB 12.00pm sign

Time 4

Retain for one year Version 2 July 01 P4550 Revised October 98 PRI 498024

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- 4 OCT 2002
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cheque T.C

TELEPHONE MESSAGE PAD / GMC criticism

FROM David Cornell (DoH)

TO file

TIME/DATE 1/10/02

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

RE: BARTON

I advised him of the current position re: 10C + 1CC.

He said that, if we heard from obtaining info. from the police or wanted other assistance in this matter to contact him.

Code A

1/10/02

Message taken by .....

TELEPHONE MESSAGE PAD

FROM Mike Gill

TO Michael Keegan

TIME/DATE 26.9.02

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dr Barton intending to go back to work next week.

Trust unable to suspend her.

wants IOC to suspend her.

→ Agreed to call him back 27/9.

→ Did so & left message that it was decided NOT to refer back to IOC on basis of Dr Tanner's letter of 19.9.02 → Dr Tanner. Told him the same.

Message taken by Code A

Code A 27.9.02

Memorandum

To **Paul Philip**
Peter Swain

From **Venessa Carroll**
Conduct Case
Presentation Section

Code A

Date **25/09/02**

Copy **Michael Keegen**

Dr Barton

1. In a letter of 19 September 2002, Hampshire and Isle of Wight Health Authority have provided a file of correspondence passed by nurses to the management of Fareham and Gosport Primary Care Trust.

2. I have listed and summarised the relevant documents contained in the file below. I have not referred to documents that I do not consider relevant.

3. The information relates to concerns that were raised in 1991 by nursing staff about the use of diamorphine. Although Dr Barton is not personally criticised, she was, with other doctors (Dr Logan), prescribing the diamorphine.

4. It would seem from the information that the nurses were extremely concerned and contacted both the RCN (Royal College fo Nursing) and Mrs Evans, the Patient Care Manager. The RCN was clearly concerned and questioned the actions of the hospital in dealing with this. It seems that by the end of 1991, the staff were satisfied that the matter had been considered and was resolved.

5. In considering whether this case should be referred back to IOC, one could consider that despite concerns being raised in 1991, Dr Barton did not address these as shown by the allegations in current case (1998). This suggests possible lack of insight and the possibility that this inappropriate practice continued from 1991 to 1998. However we have no information to support this and we have no information about Dr Barton's practice since 1998.

Information provided in File

6. **Summary of Meeting on 11 July 1991 following concerns expressed by some staff at the prescribed treatment for terminal patients.**

This was a meeting arranged for staff on unit and attended by nurses and patient care manager, Mrs Evans. Dr Barton does not appear to have attended. The main concern was use of diamorphine on patients, with the nurses concerned about it being used inappropriately. Reference is made to not all patients given diamorphine having pain, no other forms of analgesia being considered, patients deaths hastened. Mrs Evans told the nurses that Dr Barton and another Dr, Dr Logan would consider the nurse's views so long as they were based on proven

facts. Although Dr Barton is not specifically criticised, the suggestion is that the nurses were complaining about her, and possibly Dr Logan. It was agreed that more information would be obtained about diamorphine

7. **31 October 1991 - Report of a visit to unit by community tutor in continuing education, Ms Whitney.**

Purpose of visit was to discuss administration of drugs following a request for information from nurses. In attendance were a number of nurses (not Dr Barton). During this meeting the nurses identified particular cases of concern (e.g. pt prescribed diamorphine via syringe driver, when not in pain) and indicated concern that diamorpine being prescribed indiscriminately. It is noted that there are a number of cases causing nurses concern but too many to mention. Again Dr Barton is not named.

8. **4 November 1991 - Letter from community tutor enclosing copy of her report dated 31 October 1991**

Also sent to General Manager and Patient Care Manager at Gosport Hospital, as well as Principal at Solent School of Health Medicine and staff nurse at the meeting.

9. **Memo from Mrs Evans dated 7 November 1991 to all staff at unit incl Dr Logan and Dr Barton.**

Indicates that there is still concern about prescribing of diamorphine, which she has discussed with Dr Barton. Nurses asked to provide names of patients that they have concerns about so cases could be reviewed.

This memo was copied to Steve Barnes, RCN Officer.

10. **Letter to Mrs Evans from Steve Barnes dated 22 November 2001**

SB indicates that RCN office had been aware of concerns from early/mid 1991 and RCN had understood that concerns would be addressed and clear guidance/policy would follow as a result of very serious concerns. He is clearly concerned that actions have not been take to address concerns and states that they expect a clear policy to be agreed as a matter of urgency.

11. **2 December 1991, letter from RCN to Nurse Tubbritt confirming that they have the support of the RCN**

12. **Letter dated 2 December 1991 to St Mary's Hospital, Portsmouth, asking for advice on dealing with this matter**

13. **Letter from RCN to Nurse Tubbritt dated 10 December 1991** indicating that unless it is confirmed that a policy will be drawn up, then grievance procedures will be started

25 September 2002

14. **Notes of a meeting held on 17 December 1991** attended by nurses, Mrs Evans and Dr Barton. Purpose of meeting to discuss concerns about use of diamorphine. At the conclusion of this meeting it was agreed that if nurses had concerns about particular cases they could approach Dr Barton or the Sister for an explanation. Staff were asked if they felt there was a need for policy relating to nursing practice and it was agreed that it was not necessary. Mrs Evans stated that she was concerned about the way in which these matters were raised, making people defensive. Agreed that a further meeting would be arranged to ensure problems had been resolved.

15. **11 January 1992 letter from RCN concerned that problems still there.**

Michael Keegan Code A

From: Michael Keegan Code A
Sent: 23 Sep 2002 14:23
To: Venessa Carroll Code A
Subject: FW: Dr Barton

-----Original Message-----
From: Michael Keegan Code A
Sent: 23 Sep 2002 14:01
To: Paul Philip Code A Peter Swain Code A
Subject: Dr Barton

We have now received from Dr Simon Tanner, Director of Public Health at Hampshire and Isle of White Health Authority, a small file of correspondence, which was passed to the management of Fareham and Gosport Primary Care Trust by a member of staff on 16/9/02.

It includes copies of correspondence from the RCN Branch Convenor to various persons at the Trust and minutes and memoranda regarding meetings held with nursing staff to discuss their concerns about use of diamorphine in the unit.

I will provide copies of the same if you wish.

Michael.

Michael Keegan Code A

From: Michael Keegan Code A
Sent: 19 Sep 2002 10:34
To: Code A
Subject: FW: Dr Barton

Ms Chrystie,

I have recently been appointed as a Senior Caseworker with the CCPS in the GMC.

I understand that you have been instructed by the Counil in relation to Dr Barton.

I have been asked to arrange an early case conference with you involving Peter Swain, Venesa Carroll and I. May I suggest the week after next.

If you wish to discuss the matter please telephone me on the number below.

Michael Keegan
Conduct Case Presentation Section
Code A

-----Original Message-----
From: Peter Swain Code A
Sent: 19 Sep 2002 10:12
To: Venessa Carroll Code A Paul Philip Code A
Cc: Michael Keegan
Subject: RE: Dr Barton

Venessa

Thanks. We will have to consider the tactics of this. Usually, we hear the substantive case first, and then assess on the basis of the findings whether others have a case to answer for not reporting concerns earlier. However, this runs the risk that witnesses in the substantive case will not give evidence for fear of incriminating themselves. We overcame this in the Bristol case by charging the Chief Exec at the same hearing as the other doctors.

We need some early dialogue with the instructed solicitors. Please keep me informed; I will want to attend all case conferences for this case.

Peter

-----Original Message-----
From: Venessa Carroll Code A
Sent: 19 Sep 2002 09:38
To: Peter Swain Code A Paul Philip Code A
Cc: Michael Keegan Code A
Subject: Dr Barton
Importance: High

Peter and Paul

I have just spoken with Simon Tanner, Director of Public Health Code A at Portsmouth Health Authority regarding a further development in this case.

On Tuesday (17th) following the announcement about the CMO audit, ST met with Dr Barton to ensure that she was not working at the moment. Sir Liam Donaldson had indicated that voluntary restrictions on Dr's prescribing should be reintroduced. I understand that the vol undertaking had ceased following last decision of IOC to place no order. ST assured that Dr currently on sick leave.

Followign his mtg with Dr B, ST met with the staff at Gosport Hospital when 2 nurses handed over a dossier of files/letters which refer to concerns about the Dr's prescribing back as far as 1991 (as you know the current allegs relate to 1998). Included in the file are copies of minuted meetings, correspondence with the Royal College of Nursing and the Chief Executive. The report names individuals for example the CE of East Hants PCT. What this report suggests is that concerns were raised back as far as 1991 and people failed to act. By way of example, ST told me that the first page of the report which relates to a nurses mtg in 1991 refers to patients being given diamorphine when they had no pain, indiscriminate use of a syringe driver, and patients' deaths being hastened.

The report has been copied to the Police and the CMO and a copy will be sent to me.

I informed ST that the IOC is today considering Dr B's case and I would notify him, as well as Mike Gill, of the outcome.

Venessa

TELEPHONE MESSAGE PAD

FROM Ms Tessa Carroll

TO Alle: Dr Baker

TIME/DATE 26/9/02

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Contact details:

Dr Nigel McFetridge
Head Clinical Governance
Hampshire & Isle of Wight
Health Authority

Code A

Message taken by .....

FILE NOTE – 18/9/02

RE: DR BARTON (2000/2047)

Further to my fax to C S J James, to which no response had been received, I called Superintendent Paul Stickler at 4.30pm on 18 September 2002. He was at home and so unable to respond to my query in writing. He also indicated that nobody else I could speak to would be able to assist more than he.

I asked what the current 'state of play' was.

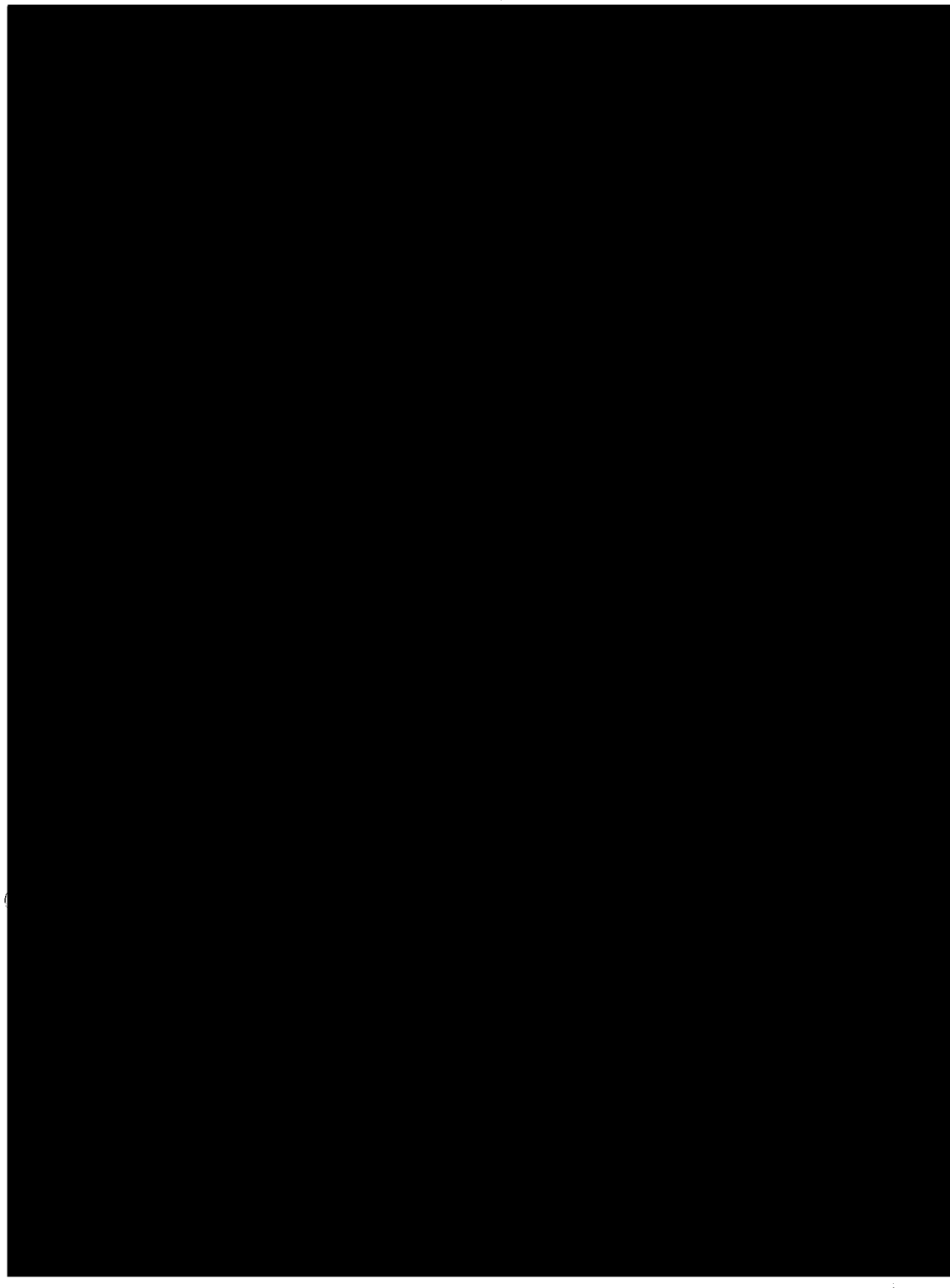
He said that his involvement was limited to having disclosed to the CPS additional papers that had not been considered re: Mrs Richards only.

He had been asked to do this following some criticism of C S James from the families of the deceased.

He said that the papers had been sent yesterday and the CPS's response was awaited, but that it would not be received before next week.

He also indicated that Steve Watts (CID) would be taking a leading role in the matter.

Michael Keegan
18/9/02



Memorandum

To Paul Philip

From Venessa Carroll
CCPS

Date 13/09/02

Copy Jackie Smith
Finlay Scott
Stephanie Day
Peter Swain

Dr Jane Barton

1. At its meeting on 29 August 2002, the Preliminary Proceedings Committee referred this case for an inquiry by the Professional Conduct Committee. It has today been referred to the Interim Orders Committee for a hearing on 19 September 2002. This will be the third time that the IOC have considered the case having previously made no order. Below I have set out, under separate headings, the history of the case and what the case is about.

The history of the case

2. In July 2000, this case began as a police investigation into the circumstances surrounding the death of Gladys Richards, a geriatric patient at Gosport War Memorial Hospital (GWMH), and was subsequently extended to 4 other deaths - Arthur 'Brian' Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

3. The case was first considered by the IOC in June 2001. At that time the police investigation was at an early stage and only Gladys Richards' death was being investigated. The information before the Committee was limited and it made no order.

4. By February 2002 the police/CPS had decided against a criminal prosecution and their papers were disclosed to the Council to decide on issues of potential spm/sdp. The case was screened in ~~May~~ February 2002 (Screener: Malcolm Lewis) who referred it to the Preliminary Proceedings Committee and also referred the case back to the IOC.

5. The IOC considered the case for the second time on 21 March 2002 and again made no order.

6. On 28 May 2002, Mrs MacKenzie (daughter of the late Gladys Richards) wrote to the GMC copying the letter to David Blunkett MP, the police, Nigel Waterson MP, Peter Viggers MP, the Police Complaints Authority, the CPS and David Parry Treasury Counsel, concerned about the failures of the police investigation. I understand that it is because of Mrs MacKenzie that the police investigation has been re-opened.

13 September 2002

7. The Rule 6 letter was sent to Dr Barton on 11 July 2002 notifying her of the PPC hearing on 29-30 August 2002. The charge set out in the Rule 6 letter is set out below.

8. In July 2002, CHI published a report titled "Gosport War Memorial Hospital: Investigation into the Portsmouth Healthcare NHS Trust". The report does not name Dr Barton specifically but refers to the criminal investigations and criticises systems in place at the time.

9. On 30 July 2002 Mrs MacKenzie informed the GMC that the police were seeking advice from the CPS about the investigation. We understand the present position to be that the CPS are reconsidering the five cases.

What the case is about

10. The Charge set out in the Rule 6 letter is set out below. You will see that the case relates to Dr Barton's prescribing to five patients between the ages of 75 and 91 between February 1998 and October 1998. These patients were attending Gosport War Memorial Hospital, mainly for rehabilitation. It was Mrs Lack's concerns (who was an experienced nurse in elderly care) about the treatment of her elderly mother (Mrs Richards) in the ward, which precipitated the reviews of other patients. Dr Barton was a visiting clinical assistant who was responsible for the day-to-day management of these five cases. Dr Barton in her defence maintains that that overwork had apparently affected patient care. There have been expert reports and in his report, Professor Ford concludes that the prescribing regime was variously reckless, excessive or highly inappropriate. The view is that death appears to have been precipitated if not caused by the drug regime in each case.

In the information it is alleged that:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a.i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

13 September 2002

b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

13 September 2002

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs Wilkie's rehabilitation needs;

4. a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

13 September 2002

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

13 September 2002

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Michael Keegan Code A

From: Michael Keegan Code A
Sent: 13 Sep 2002 10:07
To: Venessa Carroll Code A Peter Swain Code A Paul Philip Code A
Cc: Michael Keegan
Subject: Dr Barton

Rachel Dixon of the Chief Medical Officer's office called today to advise that a statement is being released today (copy to be faxed to Paul Philip's office) that a clinical audit is to be commissioned into the mortalities at Gosport War Memorial Hospital.

This has arisen as a result of concerns that the various police, CHI, etc. reports have not been adequate.

She advised that Sir Richard Baker had been commissioned to conduct the audit and that this will probably inflame press interest, as he was involved in the Shipman inquiry.

Rachel Dixon's tel no's are: Code A

Michael

Michael Keegan Code A

From: Paul Philip Code A
Sent: 12 Sep 2002 12:28
To: Venessa Carroll Code A Peter Swain Code A
Cc: Michael Keegan
Subject: RE: Inquiry re: Dr J Barton

Peter,

Can we discuss please.

Paul

-----Original Message-----
From: Venessa Carroll Code A
Sent: 12 Sep 2002 10:07
To: Peter Swain Code A
Cc: Michael Keegan Code A Paul Philip Code A
Subject: RE: Inquiry re: Dr J Barton

I have now spoken with Mike Gill who informed me in confidence that the CMO has now loooked at all the papers in this case having been notified by a whistleblower (not identified to me). The CMO wants a full investigation into the deaths in that hospital, the handling of which is going to be difficult and public as the whistleblower is likely to go to the press in a matter of days.

I informed Mike Gill that the police were again involved with this case and that Superintend. Paul Stickler was responsible for the case. Mike Gill indicated that he would contact the police.

MG is concerned that the IOC considered this case and made no order. I indicated that it was possible for IOC to reconsider if new information was placed before it. He will discuss this with the police. MG is concerned that when this becomes public, questions will be asked about Dr being allowed to continue to practise. MG used the expression "institutional euthanasia".

It was left that MG would speak to the police.

If the police are going to proceed or there is going to be an inquiry then this of course may affect any action the GMC takes.

Venessa

-----Original Message-----
From: Peter Swain Code A
Sent: 12 Sep 2002 09:13
To: Scott Geddes Code A Paul Philip Code A Venessa Carroll Code A
Cc: Michael Keegan Code A
Subject: RE: Inquiry re: Dr J Barton

Venessa

This case was allocated to Michael under your mentorship. Please could you telephone Mike Gill this morning.

Peter

-----Original Message-----
From: Scott Geddes Code A
Sent: 12 Sep 2002 09:08
To: Paul Philip Code A Peter Swain Code A
Subject: Inquiry re: Dr J Barton
Importance: High

Mike Gill, Regional Director of Public Health, SE region, telephoned thismorning (M: Code A to discuss a serious matter relating to the case of Dr J Barton, who was apparently referred by PPC to PCC end of last month.
MG asked if we could get back to him before 10:30 thismorning.

Scott

Michael Keegan Code A

From: Jonathan Inkpen Code A
Sent: 12 Sep 2002 09:40
To: Michael Keegan Code A
Subject: Dr Jane Barton 2000/2047

Michael,

I took a call from Rachel Dixon of the CMO's office. She wanted to know whether or how much of the PPC's decision to refer Dr Barton to PCC was in the public domain as Dr Barton's employers were not aware of it.

I checked with Remi and told Miss Dixon that you had only just been allocated the case and as far as I could see no-one had been notifed yet. Therefore none of the info was in the public domain, I also said we would only tell people who had a legitimate interest, but the employers would be told.

I said you would be sending out the letters asap but I did not know when as I had no idea what had to be done procedurally when notifying a doctor of a forward referral.

If you want to speak to her her number is Code A (She's not expecting you to call).

Any queries give me a shout.

Code A
Fitness to Practise
Code A

Code A

Venessa Carroll Code A

From: Peter Swain Code A
Sent: 12 Sep 2002 09:13
To: Scott Geddes Code A Paul Philip Code A Venessa Carroll Code A
Cc: Michael Keegan Code A
Subject: RE: Inquiry re: Dr J Barton

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Sent: 12 Sep 2002 08:08
To: Paul Philip Code A Peter Swain Code A
Subject: Inquiry re: Dr J Barton
Importance: High

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Scott

Next Tuesday.

CMO

Code A

Venessa Carroll Code A

From: Peter Swain Code A
Sent: 12 Sep 2002 09:13
To: Scott Geddes Code A Paul Philip Code A Venessa Carroll Code A
Cc: Michael Keegan Code A
Subject: RE: Inquiry re: Dr J Barton

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Importance: High

Mike Gill, Regional Director of Public Health, SE region, telephoned thismorning (Code A) to discuss a serious matter relating to the case of Dr J Barton, who was apparently referred by PPC to PCC end of last month. MG asked if we could get back to him before 10:30 thismorning.

Scott

Next Thursday.

TELEPHONE MESSAGE PAD

FROM .....

TO .....

TIME/DATE .....

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

File Note

Rec'd a call from Inspector Mark Wise, Hampshire police re Barton. Calling on behalf of Deputy Chief Constable who is meeting relatives of patients who died under her care this pm.

I confirmed in strict confidence that Dr Barton had been referred to PCC - stressed that letters not yet sent + relatives must not be told.

Case to be handled by Superintendant Paul Stickler Code A

Code A

11/9/02

Message taken by .....

Annex A

Investigation Instruction Sheet (IIS)

Post Preliminary Proceedings Committee Case

Section A – to be completed by the GMC

Priority Band:
A – also referred to IOC. The doctor is to be offered voluntary erasure so please do not list yet.

1. Date of instructions to solicitor:	Field Fisher Waterhouse
1. Name of doctor:	Dr Jane Ann BARTON
2. GMC file number:	2000/2047
3. Name of GMC CW: Direct line	Michael Keegan **Code A**
4. Type of case:	Conduct
5. Date for instructed solicitor to complete Section B (one week from the date of these instructions):	23 September 2002
6. Other comments:	London

Section B – to be completed by the instructed solicitor within one week of the date of these instructions.

7. Name of investigator:	John Offord (Investigator); Judith Chrystie (Solicitor)
8. Estimated number of witnesses:	12 - 15 witnesses of fact 1-3 expert witness
9. Class of case (1-5, see protocol):	Class 4
10. Target date for completion (see protocol):	6 January 2003
11. Earliest date case may be listed (taking into account the Carlile protocol):	Mid-late March 2003
12.Listing comments:	London Venue preferable owing to location of witnesses
13. Date IIS submitted by solicitor:	23 September 2002

PCC date (most
recent) requested
4.10.02.
Date: 15 days

[redacted]

Vanessa Carroll

The Guardian
14 September 2002
Page 2

Inquiry launched into 'suspicious deaths' at hospital

John Carvel
Social affairs editor

The government yesterday launched a special inquiry into the suspicious deaths of elderly people at a cottage hospital in Gosport, near Portsmouth, after relatives complained that there may have been at least nine unlawful killings.

Sir Liam Donaldson, the chief medical officer, has called in Richard Baker, a professor at Leicester University, to conduct a clinical audit of services for older people at the Gosport War Memorial hospital.

Prof Baker was the expert appointed by the Department of Health to investigate the practice of Dr Howard Shipman after his conviction as a serial killer. His finding that Shipman might have been responsible for 330 deaths persuaded ministers to expand a public inquiry into his crimes.

Officials were last night unaware of the government launching any similar clinical audit before a prosecution and conviction.

Police investigated the hospital between 1998 and 2001 after concern among relatives about the death of an elderly woman who was prescribed diamorphine. This led to allegations about the deaths of eight other patients.

Hampshire police sent papers to the crown prosecution service, which decided there was not sufficient evidence on which to base a prosecution, according to a Department of Health spokeswoman.

The commission for health improvement (CHI), the government's hospital inspectorate, said: "The police were sufficiently concerned about the care of older people at the hospital to share their concerns with us."

The CHI found there was systematic failure to provide good quality care, including insufficient guidelines on prescribing painkillers and sedatives, inadequate review of prescribing for older people and lack of supervision.

In a report in July it said: "CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998."

The inspectors were "unable to determine whether these levels of prescribing contributed to the deaths of any patients". But it was clear that this level of prescribing would have been questioned if adequate checking mechanisms had been in place.

"Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001."

However, the inspectors said they had no serious concerns about current standards.

Sir Liam's decision to mount an investigation was based on uneasiness that neither the police nor the inspection team "was in a position to establish whether trends and patterns of death were out of line with what would be expected". Inquiries of this kind are extremely unusual, officials said.

The original investigation was sparked when Gillian Mackenzie of Eastbourne, East Sussex, contacted police about the death of her 91-year-old mother in 1998.

She said at the time: "I am a realistic woman. I knew there was a chance of my mother dying when she was admitted to hospital. It is the manner she died that shocked me.

"I will never know what would have happened if she had not been prescribed diamorphine, but we must ensure that all the circumstances of these deaths are fully explained."

The Daily Telegraph
14 September 2002
Page 8

CPS to look at hospital deaths

A third inquiry into the deaths of elderly patients at a cottage hospital was announced yesterday as police said they were sending new evidence on four of them to the Crown Prosecution Service.

Nine elderly people died at Gosport War Memorial Hospital, Hampshire, amid allegations of unlawful killing and over-use of pain-killing drugs. Police are in touch with the General Medical Council and the Commission for Health Improvement.

Police first investigated the case of a 91-year-old woman. Officers were then contacted by eight other families.

The Sunday Times
15 September 2002
Page 5

Police probe 13 hospital deaths

Lois Rogers
Medical Correspondent

POLICE are investigating the deaths of 13 elderly hospital patients who relatives believe were killed with overdoses of powerful drugs, including the painkiller diamorphine.

On Friday Liam Donaldson, the chief medical officer, ordered an audit of the hospital's death rates, which will be carried out by the same expert who analysed mortality among patients of the GP Harold Shipman.

Shipman, who was sentenced to life two years ago, is believed to have killed more than 250 elderly people by giving them overdoses of diamorphine, the pure form of heroin that is used as a painkiller but is lethal in overdose.

All 13 of the Hampshire patients were admitted to Gosport War Memorial hospital between 1997 and 2000 to recover from various operations and treatments. None of their families was told at the time of admission that their relatives were expected to die.

Jane Barton, a GP who was in day-to-day charge of medical care at the hospital until July 2000, was referred to the General Medical Council's professional conduct committee last week. A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

However, there is no suggestion that Barton, who has refused to comment, or any of the others who worked on the wards deliberately caused harm to any patient.

Among the cases being probed are the deaths of:

- Elsie Devine, 88, who was admitted to the hospital to recover from a kidney infection. Her relatives were urged to leave the hospital shortly before she died. They were stunned to discover she had been given large doses of diamorphine.
- Leonard Graham, 75, who was recovering from pneumonia. His wife was "told" to ring her daughter while a drug dose was administered. He died shortly afterwards.
- Betty Rogers, 67, who was recovering from a chest infection. Her daughter was urged to go home having been told her mother was not near death. Fifteen minutes later she received a call saying she had died.

Other deaths under investigation include Stanley Carby, 65, Eva Page, 88, and Dulcie Middleton, 85.

Among those who are helping the police with their inquiries is Jim Ripley, a 76-year-old gout sufferer who was admitted to Gosport War Memorial hospital in April 2000. He narrowly escaped death after falling into a painkiller-induced coma on one of the three wards now under investigation. It took five hours for an emergency doctor to arrive after he lost consciousness at hospital. He was transferred to the nearby Haslar hospital where staff soon established he had not had a stroke, as was first suspected, but was in an "analgesic coma".

A number of families were advised to take holidays during their relatives' last hours. "Why did they tell me to go on holiday? Surely they knew he was going to die," said Dorie Graham, whose husband Leonard died in 2000. She complained to the police more than a year ago.

Edna Purnell, 91, entered the hospital for rehabilitation after a hip replacement. She was put in a darkened room and heavily sedated, according to Mike Wilson, her son. Wilson consulted a solicitor and tried to get her moved to a private hospital. He was then himself rushed into hospital after a heart attack and while he was there she died.

The medical notes of Alice Wilkie, 88, record her as having died twice on the same day. Her granddaughter Emily Yeats believes this is because her files were mixed with those of Gladys Richards, 91, who died hours later. Both received cocktails of painkillers that investigations by the Commission for Health Improvement (CHI) revealed should not have been used together.

A CHI report into the hospital's practice, published in July, criticised the use of diamorphine combined with a strong anaesthetic, and another drug usually used to treat schizophrenia. This combination, the report said, "could carry a risk of excessive sedation and respiratory depression in older patients, leading to death".

The CHI was originally asked to investigate the hospital by the police, who had begun a criminal investigation into the 1998 death of Richards, after her family alleged she had been unlawfully killed.

Although the CHI report said it could not look at any particular death, it found doses of up to 200 milligrams a day of morphine were being administered through pumps into patients' bloodstreams. Prescriptions for morphine and other potent drugs were regularly written in advance, so that nurses could administer them unsupervised.

Ian Piper, the chief executive of the Gosport and Fareham primary care trust, which now administers the hospital, said he could not comment on individual cases. The trust has just sent its first draft of proposals to meet the 22 recommendations for change in the CHI report. Standards of care at the hospital had improved, said Piper.

Families of 10 of the dead patients attended a meeting called by Ian Readhead, deputy chief constable of Hampshire, last week. Police said a file on the affair will be sent to the Crown Prosecution Service this month. The Nursing and Midwifery Council said it was investigating disciplinary proceedings against several nurses.

Donaldson has commissioned Richard Baker, professor of clinical governance at Leicester University, to repeat the statistical analysis he conducted into Shipman's practice.

Donaldson said previous inquiries into patient concerns at Gosport had not established whether patterns of death were "out of line with what would be expected". Baker will seek to answer the question fully.

News of the World
15 September 2002

New old folks death probe

THE professor who investigated serial killer Dr Harold Shipman is to head a probe into hospital deaths.

Richard Barker will lead the third inquiry into the deaths of at least eight elderly patients at Gosport War Memorial Hospital, Hants.

Code A

Daily Mail (Late)
16 September 2002
Page 19

Shipman case expert heads hospital probe

AN expert who worked on the case of mass murderer Harold Shipman is to head an inquiry into the deaths of 13 patients at a hospital.

There are fears that some who died at Gosport Royal Memorial Hospital in Hampshire between 1997 and 2000 may have been killed by a drug overdose.

Files on several of the cases are being sent to the Crown Prosecution Service although there is no suggestion that any of the patients was harmed deliberately.

The investigation began after families raised concerns that their relatives may have been given overdoses of drugs including diamorphine.

Professor Richard Baker of Leicester University has been commissioned to study the deaths. He analysed death rates at GP Harold Shipman's practice in Hyde, Greater Manchester.

Shipman is serving life for murdering 15 patients but has been blamed for killing 200 more.

Jackie Smith

The Times
7 November 2002
Page 3

Shipman-style inquiry into 50 deaths at hospital

By Michael Horsnell and Russell Jenkins

AN EXPERT in the use of diamorphine, the heroin-based painkiller, is to be appointed by police conducting an investigation into the suspicious deaths of more than 50 elderly patients at a community hospital.

Relatives allege that the drug, used by Harold Shipman to kill many of his patients, was over-prescribed at the Gosport War Memorial Hospital in Hampshire. Detectives are preparing to interview relatives of those who died at the 180-bed hospital amid claims of unlawful killing.

Many patients died while receiving recuperative care under a regime in which prescriptions for morphine and other potent drugs were regularly written in advance so that nurses could administer them unsupervised.

Ann Alexander, a solicitor who represented more than 300 families in the Shipman inquiry, had a two-hour meeting with Detective Chief Superintendent Steve Watts of Hampshire police and his deputy Nigel Neven yesterday.

She said: "It was a very productive meeting. They have completely reassured me about their intentions to do whatever they can to get to the bottom of whatever has been going on at this hospital."

After complaints by some relatives that police had failed to respond fully to initial concerns, it was disclosed that officers will examine how Greater Manchester Police put together the Shipman inquiry, notably its use of expert witnesses. Ms Alexander said: "Police want to see every single family that wishes to see them. They are hoping that anyone who has not been in touch and who has concerns should come forward."

The meeting, at her office in Altrincham, Greater Manchester, came after worried families contacted a helpline established by health managers. A total of 57 people attended a public meeting held by Alexander Harris, solicitors, on Sunday to hear concerns about treatment at the hospital dating back to the early 1990s.

The law firm represents relatives of 27 elderly patients who died at the hospital and one who survived, but there are believed to be at least as many again whom detectives want to contact.

Among the cases under investigation are those of Leonard Graham, 75, who was recovering from pneumonia. Another, Betty Rogers, 67, was recovering from a chest infection. Her daughter was urged to go home, having been told her mother was not near death. Fifteen minutes later she received a call saying her mother had died.

Other deaths under investigation include those of Stanley Carby, 65, Eva Page, 88, and Dulcie Middleton, 85.

The hospital has already been the subject of an investigation by the Commission for Health Improvement, which criticised its prescribing practices. Althought a commission report said that it could not look at any particular death, it found doses of up to 200 milligrams a day of morphine were being administered by pumps.

In September the government's chief medical officer commissioned a clinical audit. Professor Richard Baker, who worked on the Shipman inquiry, was appointed to examine death rates at the hospital.

In the same month the chief executives responsible for managing the hospital at the time of the deaths were suspended. Ian Piper, of Fareham and Gosport Primary Care Trust, and Tony Horne, of East Hampshire Primary Care Trust, were redeployed to other duties. The suspensions were prompted after internal documents from 1991 — prior to the deaths — were uncovered which highlighted concerns about prescribing practices at the hospital. The hospital has moved to reassure current patients by appointing an experienced senior nurse from another area to oversee and review patient care.

Jane Barton, who was in charge of the day-to-day treatment of some elderly patients at the hospital until July 2000, was referred to the General Medical Council in September. A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

There is no suggestion that Dr Barton, who has refused to comment, or any of the others who worked at the hospital, deliberately caused harm.

The Hampshire and Isle of Wight Health Authority said: "It is important to note that whilst the CHI investigation had some serious concerns about services in the past, it concluded that policies and procedures are now in place to ensure safe standards of care at the hospital."

Hampshire police said: "Detective Chief Superintendent Steve Watts today had a meeting with Alexander Harris in Altrincham who are representing the families of people who died at the Gosport War Memorial Hospital. Senior members of his investigating team were at the meeting. The investigation is ongoing."

The Times
7 November 2002
Page 3

Relatives tell of their anguish

Case History 1:

ANNE REEVES would have looked after her mother at her home in Fareham, Hants after the elderly widow completed successful treatment for a kidney infection at Queen Alexandra Hospital, Portsmouth.

But her own husband was also in hospital, having a bone marrow transplant for leukaemia. So it seemed a sensible idea for Elsie Devine, 88, to recuperate at the War Memorial Hospital in Gosport. She died on November 21, 1999.

Mrs Reeves said: "She had been doing very well. Then on November 19 my brother Harry visited and was met by Jane Barton who said mother was in kidney failure and had 36 hours to live.

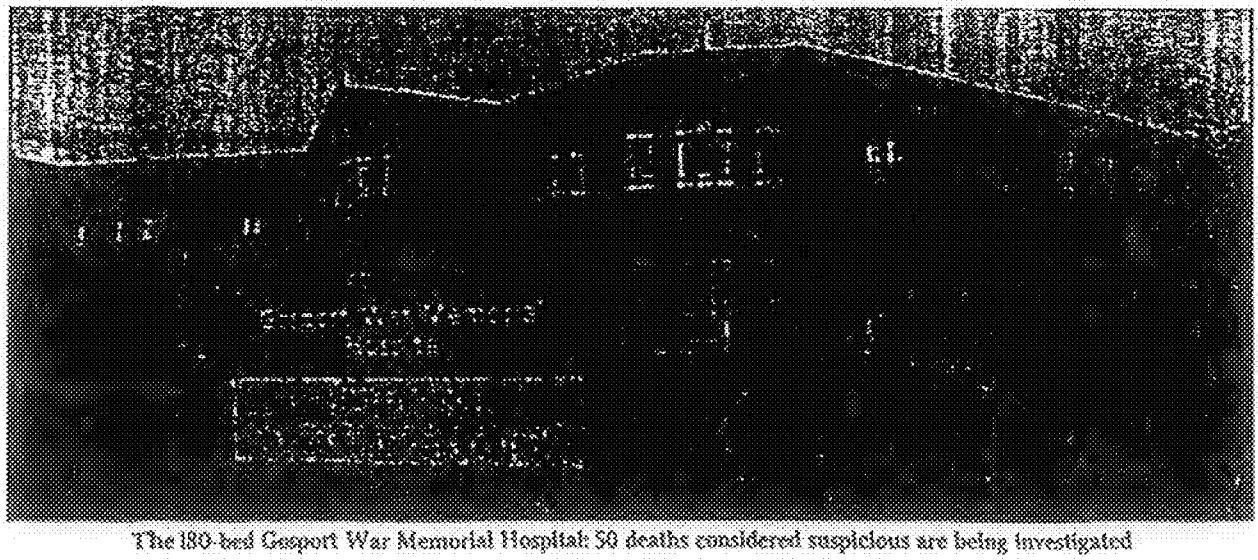
"She couldn't speak and couldn't open her eyes. She was just lying there."

Mrs Reeves, who has obtained her mother's drug charts, added: "She had been put on a cocktail of sedatives and, in the end, it killed her. I don't know why, because she wasn't in any pain."

Case History 2:

FORMER dockyard worker Jim Ripley, 78, went into the hospital for recuperation from arthritis and bursitis in April 2000 but after a couple of days he started hallucinating.

On the morning of April 8 he became unconscious and despite calls by his wife Paula at 8.30am for a doctor to see him, he was not seen until after 3pm that day. The doctor originally suspected he had suffered a stroke but, after he was transferred to another hospital, he was diagnosed as having suffered an analgesic coma caused by overprescription of morphine, according to Mrs Ripley. She said: "I am extremely angry but very lucky that my husband is alive and so very, very sorry for everyone else that lost their family. My husband had turned from being a strong elderly man to a frightened old man and it was pitiful to see."



The 180-bed Gosport War Memorial Hospital: 50 deaths considered suspicious are being investigated

TIMES ONLINE PRINT THIS ARTICLE

November 07, 2002

Shipman-style inquiry into 50 deaths at hospital

BY MICHAEL HORSNELL AND RUSSELL JENKINS

AN EXPERT in the use of the heroin-based painkiller diamorphine is to be appointed by police conducting an investigation into the deaths of more than 50 elderly patients at a community hospital.

Relations allege that the drug, used by Harold Shipman to kill many of his patients, was overprescribed at the Gosport War Memorial Hospital near Portsmouth.

Detectives are preparing to interview relations of those who died at the 180-bed hospital amid claims of unlawful killing. Many patients died while receiving recuperative care under a regime in which prescriptions for morphine and other potent drugs, it is claimed, were regularly written in advance so that nurses could administer them unsupervised.

Ann Alexander, a solicitor who represented more than 300 families in the Shipman inquiry, had a two-hour meeting with Detective Chief Superintendent Steve Watts, of Hampshire police, and his deputy, Nigel Neven, yesterday.

She said: "It was a very productive meeting. They have completely reassured me about their intentions to do whatever they can to get to the bottom of whatever has been going on at this hospital."

After complaints by relations that police had failed to respond fully to initial concerns, it was disclosed that officers will look at how Greater Manchester Police organised the Shipman inquiry, notably its use of expert witnesses. Ms Alexander said: "The police want to see every single family that wishes to see them. They are hoping that anyone who has not been in touch and who has concerns should come forward."

The meeting, at her office in Altrincham, near Manchester, came after worried families contacted a helpline set up by health managers. A total of 57 people attended a public meeting held by Alexander Harris, a firm of solicitors, on Sunday to hear concerns about treatment at the hospital dating back to the early 1990s.

The firm represents relations of 27 elderly patients who died at the hospital and one who survived, but there are believed to be at least as many again whom detectives want to contact. Among the cases under investigation are those of Leonard Graham, 75, who was recovering from pneumonia. Another, Betty Rogers, 67, was recovering from a chest infection. The patient's daughter was urged to go home, having been told that she was not near death. Fifteen minutes later she received a call to say that her mother had died.

Other deaths under investigation include those of Stanley Carby, 65,

Eva Page, 88, and Dulcie Middleton, 85.

The hospital has already been the subject of an investigation by the Commission for Health Improvement, which criticised its prescribing practices. Althought a commission report said that it could not look at any particular death, it found that doses of up to 200 milligrams a day of morphine were being administered by pumps.

In September, the Government's Chief Medical Officer commissioned a clinical audit. Professor Richard Baker, who worked on the Shipman inquiry, was appointed to examine death rates at the hospital.

In the same month, the chief executives responsible for managing the hospital at the time of the deaths were suspended. Ian Piper, of Fareham and Gosport Primary Care Trust, and Tony Horne, of East Hampshire Primary Care Trust, were moved to other duties. The suspensions were prompted after internal documents from 1991, before the deaths, were found which highlighted concerns about the hospital's prescribing practices.

It has sought to reassure its present patients by appointing a senior nurse from another area to review patient care.

Jane Barton, who was in charge of the day-to-day treatment of some elderly patients at the hospital until July 2000, was referred to the General Medical Council in September.

A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

There is no suggestion that Dr Barton, who has refused to comment, or any of the other people who worked at the hospital, deliberately caused harm.

The Hampshire and Isle of Wight Health Authority said: "It is important to note that, while the (Commission for Health Improvement) investigation had some serious concerns about services in the past, it concluded that policies and procedures are now in place to ensure safe standards of care at the hospital."

Hampshire police acknowledged that a meeting between Mr Watts and Alexander Harris, representing the families of people who died at the Gosport hospital, had taken place.

Unrelated doctor information [redacted]

17.	**2000/2047**	**BARTON, J A**	**Refer to PCC**	**CCPS**	The Committee initially was informed by the Committee Secretary that the case of patient Gladys Richards has been referred back to the CPS. It noted that the case related to five patients between the ages of 75–91 who were attending Gosport War Memorial Hospital, mainly for rehabilitation. One person (Mrs Lack) who was an experienced nurse in elderly care was concerned about the treatment of her elderly mother (Mrs Richards) in the ward, which precipitated the reviews of other patients. The Committee noted the fairly brief report of Dr Mundy, and Professor Ford's report which looked at all five cases. It noted the background to the case as a whole, which was that Dr Barton was a visiting clinical assistant who was responsible for the day-to-day management of these five cases. It noted that overwork had apparently affected patient care. It noted that in the case of Mrs Richards she had lost a hearing aid and her spectacles, and was

					brought in in an agitated state, probably because of sensory deprivation. She became ambulant with a Zimmer, but her hip replacement became dislocated following a fall. This patient was prescribed the same set of drugs which was used in each of the other cases: Oramorph, hyoscine and midazolam. It noted that some patients had up to 60–80 mg in 24 hours via subcutaneous injection with a syringe driver. Patient Richards received no foods or fluids between 18 – 21 August and died because of the combination of lack of nutrition and sedation. The Committee considered that the administration of these drugs may have shortened the patient's life (which was not the same as suggesting that it killed her). Professor Ford says that the prescribing regime was variously reckless, excessive or highly inappropriate. It noted with concern that the medical records are not signed regarding the subcutaneous drugs regime. It noted the pattern in which an elderly group of patients, dealt with by a clinical assistant, were the subject of apparently reckless and inappropriate prescribing. Death appeared to have been precipitated if not caused by the drug regime in each case. The Committee noted that Dr Barton's post was supervised by a consultant, Dr Lord, who must therefore assume some responsibility for the events. It noted that palliative care is now a well-developed clinical area. If death is accelerated as a result of carefully titrated, good symptoms control, then as a side-effect it may be acceptable. This did not appear to be the case here, and the Committee was of the view that the matter unequivocally needs to be tested by the Professional Conduct Committee. Dr Barton moved patients very quickly onto a regime where they were receiving terminal care, and ignored the recommendations regarding doses in the BNF, rapidly prescribing excessive doses. It noted that there was a major public interest in the case. It asked that we look at charges 2 (b) ii) and iii) regarding Eva Page, as these would not raise an issue of spm (ask solicitors to look at charges). It noted that the case had been before the IOC which had made no order. The Committee considered that the case of Dr Lord should be screened if it hasn't already been. It further suggested that if the allegations against Dr Lord have already been screened, we might now have more information than the screener had at the time, and it may need to be re-screened. It considered that the nurses involved were open to criticism for withholding nutrition and for failing in their own whistle-

					blowing responsibilities, and should be referred to the UKCC. It noted that there has already been a CHI report. The Committee noted that the documentation which was not included may contain information about the identity of the nurses concerned, and that a Nurse Philip Beed is named at p236. If we cannot identify other nurses we should ask the Trust for the names so they can be reported to the UKCC. We should also warn the press office about the case given the potential public interest, mentioning that other doctors and nurses might become involved. The Committee would like the case to be fast-tracked. Professor MacSween requested that a charge be added at 5 a. iii to reflect the inappropriate use of the word "happy" in the context of confirming death as this was at best inappropriate and reflected an attitude which caused considerable concern.

Unrelated doctor information [redacted]

Venessa Carroll Code A

From: Christine Payne Code A
Sent: 29 Aug 2002 10:04
To: Venessa Carroll Code A
Subject: Dr Barton-URGENT message

Importance: High

You should probably tell the PPC about the information re point 2 below. Thanks
Christine

-----Original Message-----
From: Michael Hudspith Code A
Sent: 29 Aug 2002 10:03
To: Christine Payne Code A
Subject: FW: Phone messages

Please see point 2 for info in case of Jane Barton. Gillian McKenzie is the daughter of patinet Gladys Richards.

Mike

-----Original Message-----
From: Helen Morran Code A
Sent: 29 Aug 2002 10:00
To: Michael Hudspith Code A
Subject: Phone messages

Mike

I took two calls for you yesterday.

1. DS Lyons rang about the case of Dr Sinha, which she said you were dealing with. She just wanted to let you know that she has spoken to Dr Sinha and explained that the Police want to interview him under caution. He is seeking legal advice about this interview.

She will keep you updated on further developments.

2. Gillian Mackenzie phoned to say that she has had a letter from Police HQ in Winchester to say her papers re: Dr Barton are being referred back to the CPS. She wondered if you had been notified of this.

Thanks

Helen

Venessa Carroll Code A

From: Christine Payne Code A
Sent: 28 Aug 2002 10:24
To: Venessa Carroll Code A
Subject: RE: Dr Barton

I have spoken to Ian Barker - he is content that CHI report is flagged up as being available to Chairman. I will place on file (Barton has its won box!)
Christine

-----Original Message-----
From: Venessa Carroll Code A
Sent: 27 Aug 2002 14:44
To: Christine Payne Code A
Subject: RE: Dr Barton

okay. thanks

-----Original Message-----
From: Christine Payne Code A
Sent: 27 Aug 2002 14:37
To: Venessa Carroll Code A
Subject: Dr Barton

Venessa
This case is in PPC day 1. CHI have prepared a report which has just been sent to us. It does not name Dr Barton specifically but refers to the criminal investigations and criticises systems in place at the time. I have a call out to Ian Barker at MDU to see if he wishes for report to be made available to PPC; if not it can be on file but I am not sure how necessary it is for PPC to know about it - it could be flagged up to Chairman though.
Christine

Venessa Carroll Code A

From: Christine Payne Code A
Sent: 27 Aug 2002 16:03
To: Venessa Carroll Code A
Subject: FW: Dr Jane Barton (PPC 29/08/02)

For information

-----Original Message-----
From: Michael Hudspith Code A
Sent: 07 Aug 2002 13:45
To: Christine Payne Code A
Subject: Dr Jane Barton (PPC 29/08/02)

Christine

Please see message below for information. Mrs McKenzie is the daughter of Gladys Richards, one of the patients whose death we are looking into. Her contact details are on the case file.

Should the case proceed to PCC our solicitors may wish to be aware of other possible complaints with a view to possibly adding these in.

Mrs McKenzie has also requested that when looking at the case the PPC also be asked to consider referring the matter back to the police and ask them to re-open their investigation. I have informed Mrs McKenzie that I have never heard this done and was not sure that it would even be appropriate in this case as

1) the information came from the police in the first place and they have already deceided (on advice from CPS) not to bring charges

2) the CPS's area of expertise is criminal law and ours is professional conduct and performance. It is not our place to advise or suggest to the CPS that their original decision was flawed and should be revisited.

Hope this is clear. Any questions please ask.

Mike

-----Original Message-----
From: Seaton Giles Code A
Sent: 30 Jul 2002 11:42
To: Michael Hudspith Code A
Subject: Phone call

For info:

Gillian McKenzie called re: Dr Barton & Gosport War Memorial Hospital. She wished to inform us that the Deputy Chief Constable of Hants Police was seeking further advice from the CPS regarding the investigation into Dr Barton's actions. She also stated that following publicity, she is now aware of a further 6 cases.

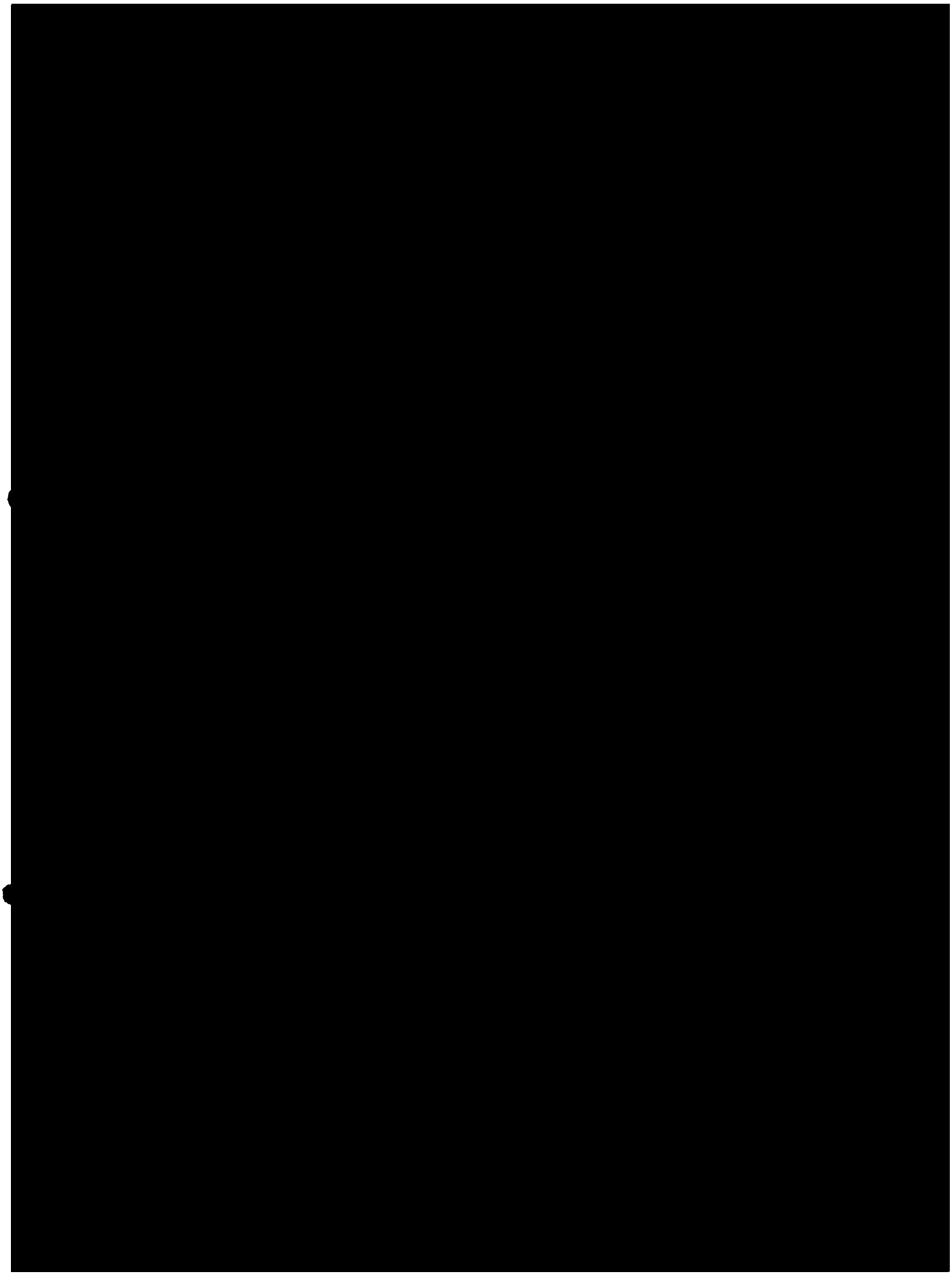
Thanks

Seaton

Venessa Carroll Code A

From: Christine Payne Code A
Sent: 27 Aug 2002 14:37
To: Venessa Carroll Code A
Subject: Dr Barton

Venessa
This case is in PPC day 1. CHI have prepared a report which has just been sent to us. It does not name Dr Barton specifically but refers to the criminal investigations and criticises systems in place at the time. I have a call out to Ian Barker at MDU to see if he wishes for report to be made available to PPC; if not it can be on file but I am not sure how necessary it is for PPC to know about it - it could be flagged up to Chairman though.
Christine



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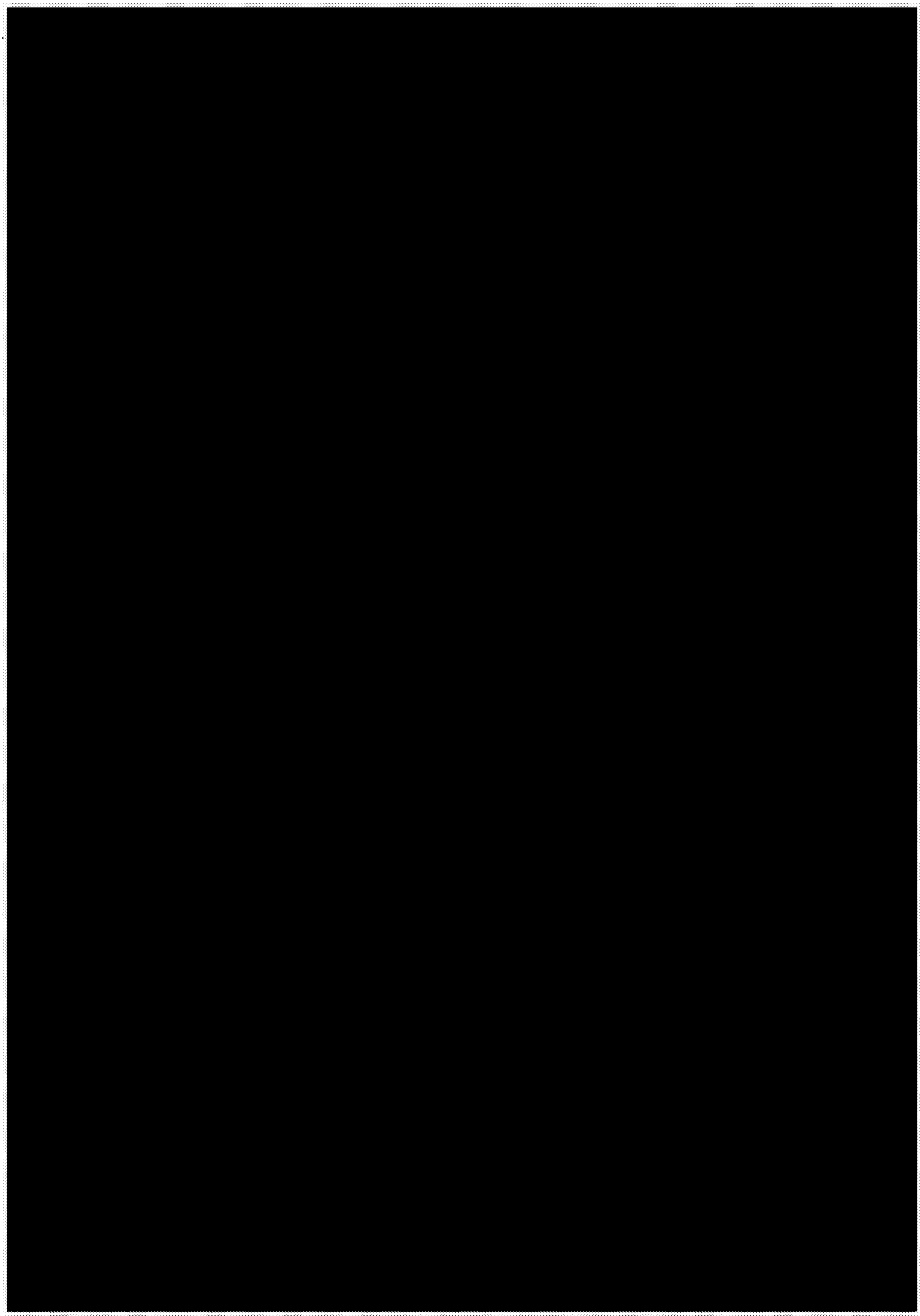
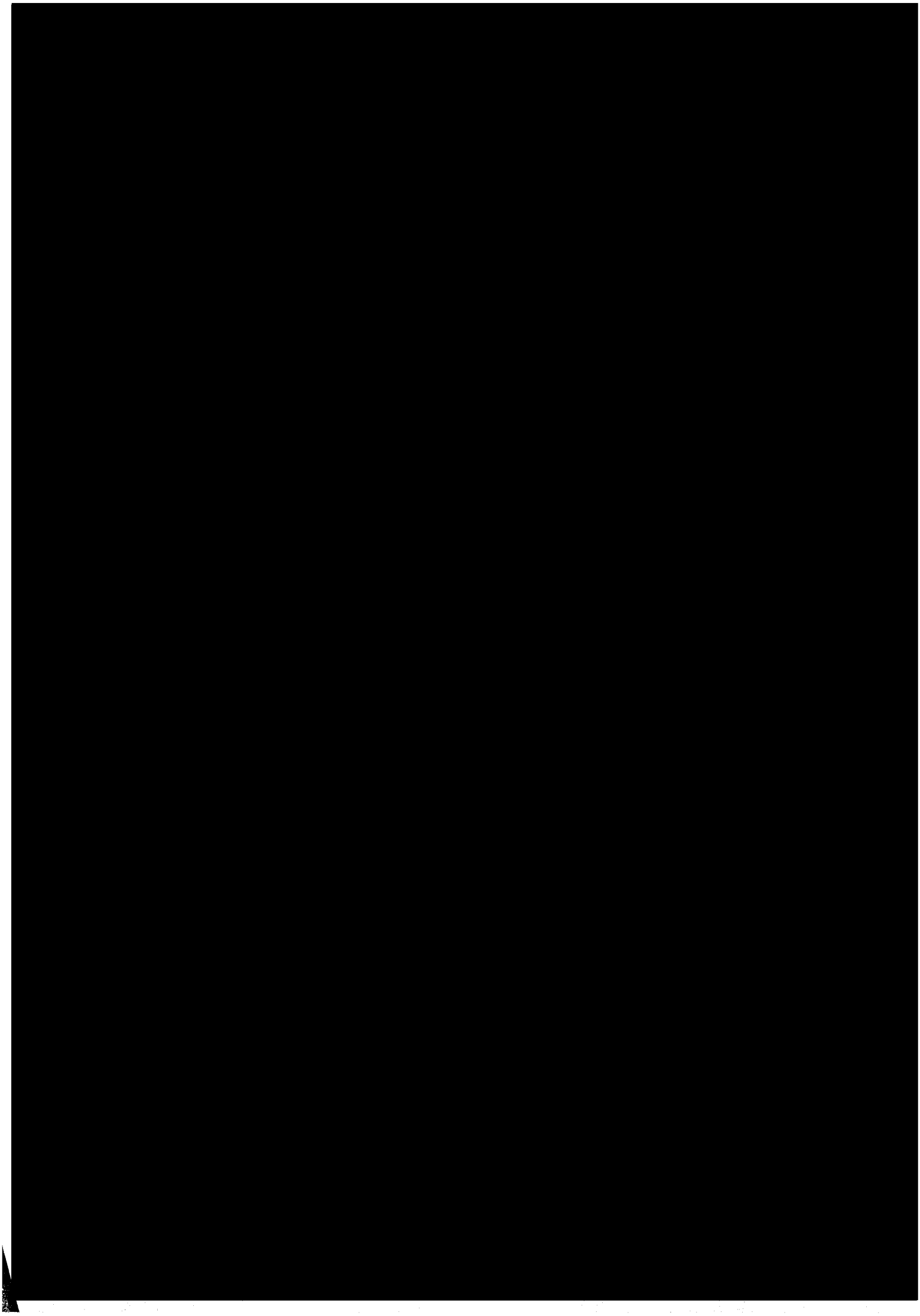


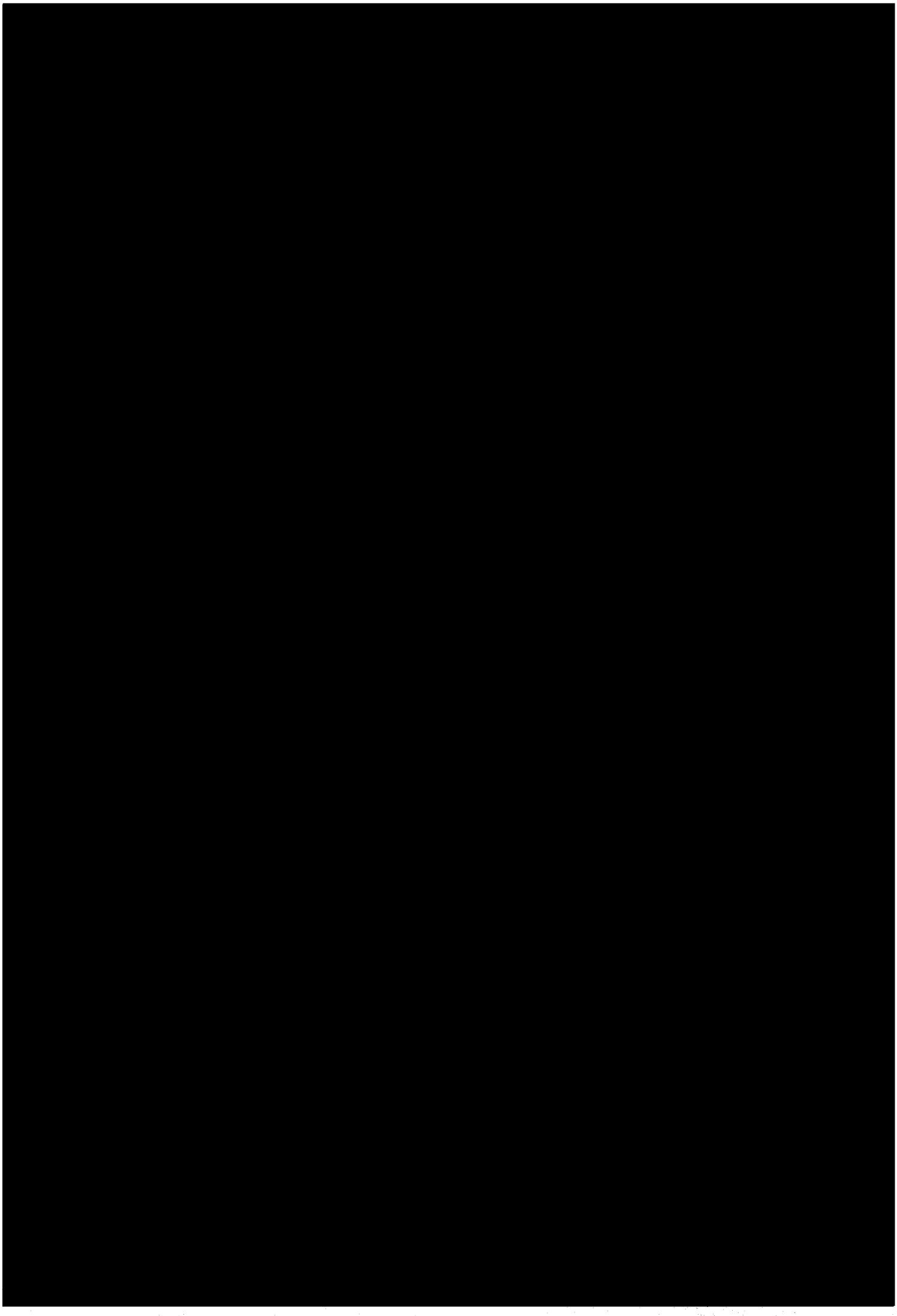
2000/2047
Dr J A Barton

Chronology for GMC case (to 18 May 2004)

27/07/00	Hampshire Constabulary notify GMC of allegation by Gladys Richards' family that she had been unlawfully killed as a result of treatment received at Gosport War Memorial Hospital and confirmed that Dr Barton appeared to be responsible for her care.
June 2001	IOC considered and made no order.
February 2002	CPS decide not to proceed with criminal case. Disclosure to GMC of Crown's papers which includeda report on the management of a further four patients at Gosport War memorial Hospital.
21 March 2002	IOC considered again, including the additional information on the four patients, and made no order.
29 August 2002	PPC considered and referred the five cases to PCC.
August 2002	Police send their case papers to CPS because of concerns by family members that there was no case to be raised against Dr Barton.
19 September 2002	IOC considered and made no order.
19 September 2002	Hampshire and Isle of Wight NHS Health Authority sent to GMC a file of correspondence relating to concerns about the use of diamorphone on patients in 1991. GMC consulted Matthew Lohn as to whether this merited a further referral to IOC.
9 October 2002	Matthew Lohn replies that "... Screeners would be misdirecting themselves if, having seen the new papers, they were to refer the matter for further consideration by the IOC".
September/October 2002	Police reopened their investigation and the GMC's investigation put on hold. Police decide to investigate all deaths of patients under Dr Barton's care at the Hospital.

30 September 2003	Police meet with Linda Quinn, GMC, and said that following a review by experts, the findings in respect of the patients' deaths were that 25% were optimal, 50% were sub-optimal but causation unclear, 25% cause of death unclear (all percentages approximate). Police asked whether the case would be reconsidered by IOC on the basis of this information, but would not agree to disclose any of their papers because they knew that GMC would have to disclose to doctor if the case were to go back to IOC.
October 2003	Matter referred to Screener, with all available information. Screener does not consider that it should go back to IOC.
7 January 2004	LQ requests update on progress from police.
28 January 2004	Police indicate that unable to provide further information at that point.
6 February 2004	LQ confirms to police that GMC inquiries on hold pending conclusion of their investigations.
February 2004	Paul Philip meets with CMO, at CMO's request, to discuss Barton case and Richard Baker's report (which PP had not seen in advance of meeting).
27 February 2004	Meeting between GMC (Paul Philip, Jackie Smith and Linda Quinn), Hampshire Constabulary (DCS Watts, DI Niven and one other) and FFW (Matthew Lohn). To summarise police's position, they were still investigating, did not know when the investigation would be complete, did not know when they would be ready to interview Dr Barton, and were not willing to give the GMC any information/evidence unless the GMC guaranteed not to pass it on to Dr Barton.
5 May 2004	Peter Steel wrote to Hampshire Constabulary.





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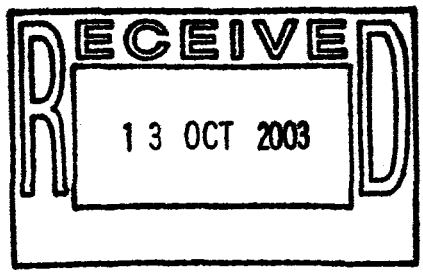


Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

S Watts MSc DPM MIMgt
Detective Chief Superintendent
Head of CID

Code A

Your ref:

Our ref: SW/chm

6th October 2003

Ms L Quinn
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Ms Quinn

Re: **Gosport War Memorial Hospital - Operation Rochester**

Thank you for your letter dated 2 October 2003, following our meeting on 30 September 2003 regarding the above matter.

I note your comments, in particular the processes by which the GMC may consider the matter of registration.

The summary which we provided you in respect of our investigation, indicated that a team of clinical experts had examined hospital records in respect of 62 patients at Gosport War Memorial Hospital, under the care of Dr Barton. In a significant number of those cases, the experts take the view that there was negligent care and that the causation of death is unclear. As my colleague DI Niven and I explained, much further work needs to be done to validate and develop these very provisional findings. We took the view, however that the GMC and the relevant Strategic Health Authority should be appraised of this information.

As we explained to you, our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegation such those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to the public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton.

Our investigation has only considered cases up to 1998 and all relate to the treatment of patients at the Gosport War Memorial Hospital. All the cases of concern raise issues in respect of the use of opiates. My understanding at the present time is that Dr Barton is not allowed to work at the Gosport War Memorial Hospital, and is not authorized to prescribe opiates.

On the basis of the above, I think more assessment needs to be conducted to quantify and clarify the risk that Dr Barton continuing to practice currently presents to the public safety. I would emphasize that our investigation has only concerned itself with issues within the Gosport War Memorial Hospital and not in any other area of practice by any medical staff. You will be aware that Professor Richard Baker was tasked with conducting some analysis by the Chief Medical Officer. His remit would have been wider than ours and although I do not know the outcome of his research, I would imagine any conclusions he has reached might assist you in your deliberations.

It is probable that we will need to interview Dr Barton at length. The interview process is predicated upon a detailed strategy which will include a careful consideration of the information supplied to Dr Barton prior to interview. I note that your letter indicates that any information supplied to the GMC will in its totality be supplied to Dr Barton. Any uncontrolled disclosure to Dr Barton has the potential to detrimentally impact upon the investigation, and I therefore would be reluctant to disclose further information until the above issue of risk has been given thorough consideration.

If I were reassured that material would not be passed to Dr Barton or her representatives, I would be willing to consider, at a future time, providing a more detailed disclosure of information to the GMC. We would be more than happy to discuss with the GMC 'Screener' how we may best achieve the maximum disclosure without a detrimental impact upon the investigation.

Finally, in answer to your question, I can confirm that the patients that you name in the second page of your letter of 30 September were included in those reviewed by the team of clinical experts.

I look forward to hearing from you so that we may progress this matter together.

Yours sincerely

Code A

Steve Watts
Detective Chief Superintendent
Head of CID

Linda Quinn Code A

From: Lohn, Matthew Code A
Sent: 11 Feb 2004 19:23
To: GMC - Linda Quinn (7344 4700)
Subject: RE: Dr Jane Barton

Hopefully about 10.30

-----Original Message-----
From: GMC - Linda Quinn Code A
Sent: Wednesday, February 11, 2004 4:25 PM
To: Lohn, Matthew; GMC - Linda Quinn Code A
Cc: Chrystie, Judith
Subject: RE: Dr Jane Barton

Yes, I am around in the morning. What time were you thinking of?

Linda

-----Original Message-----
From: Lohn, Matthew Code A
Sent: 11 Feb 2004 16:27
To: GMC - Linda Quinn (7344 4700)
Cc: Chrystie, Judith
Subject: Dr Jane Barton

Are you around tomorrow morning for 5 mins to discuss this case?

I am over at the GMC and could pop round

Regards

Matthew

Matthew Lohn
Field Fisher Waterhouse
Code A
www.ffw.com

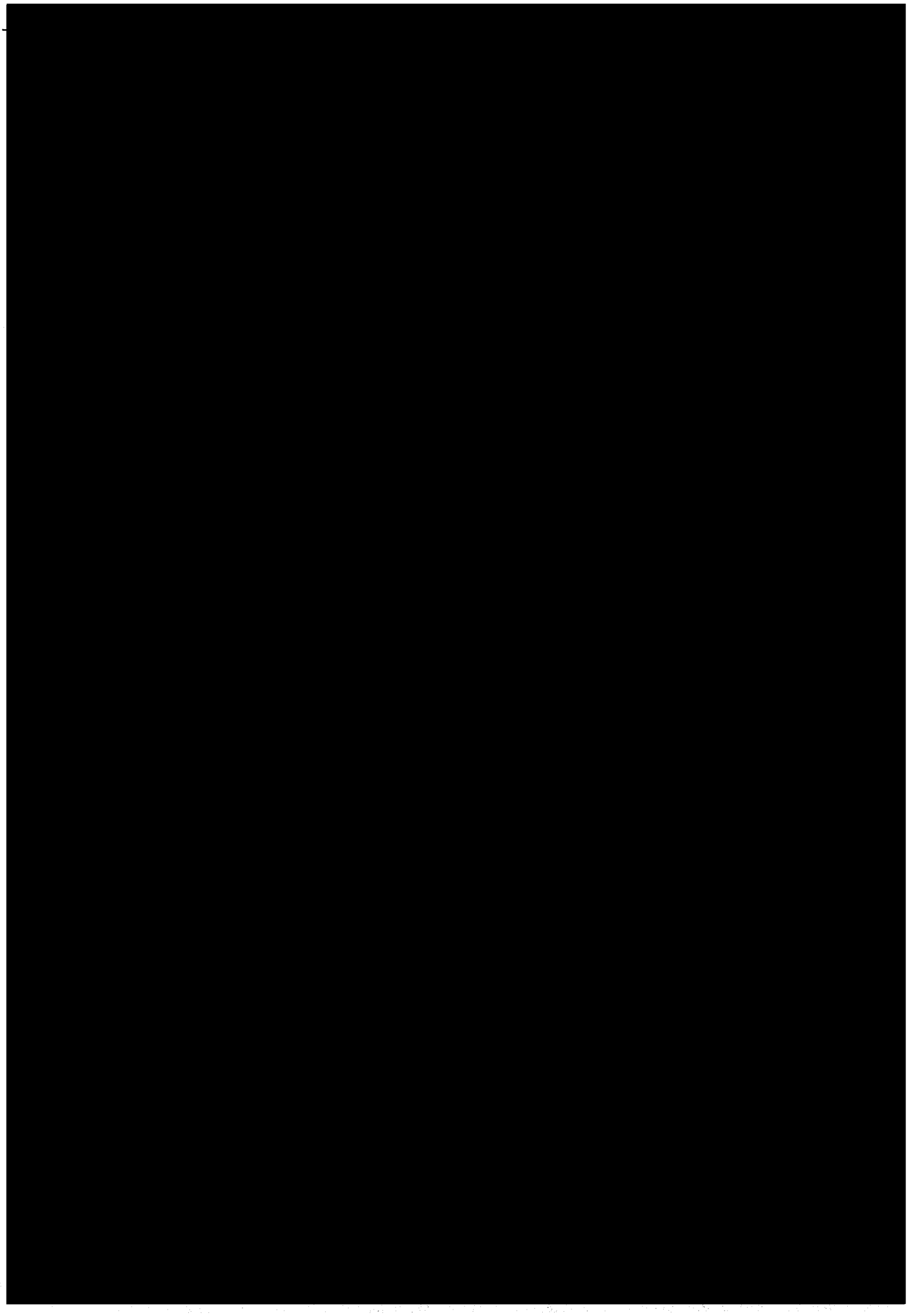
Linda Quinn Code A

From: Chrystie, Judith Code A
Sent: 11 Feb 2004 19:11
To: GMC - Linda Quinn (7344 4700)
Subject: Out of Office AutoReply: Dr Jane Barton

I am out of the office until 13 February 2004

Should you require any urgent assistance, please contact my secretary Hayley Ashdown on Code A.

[redacted]



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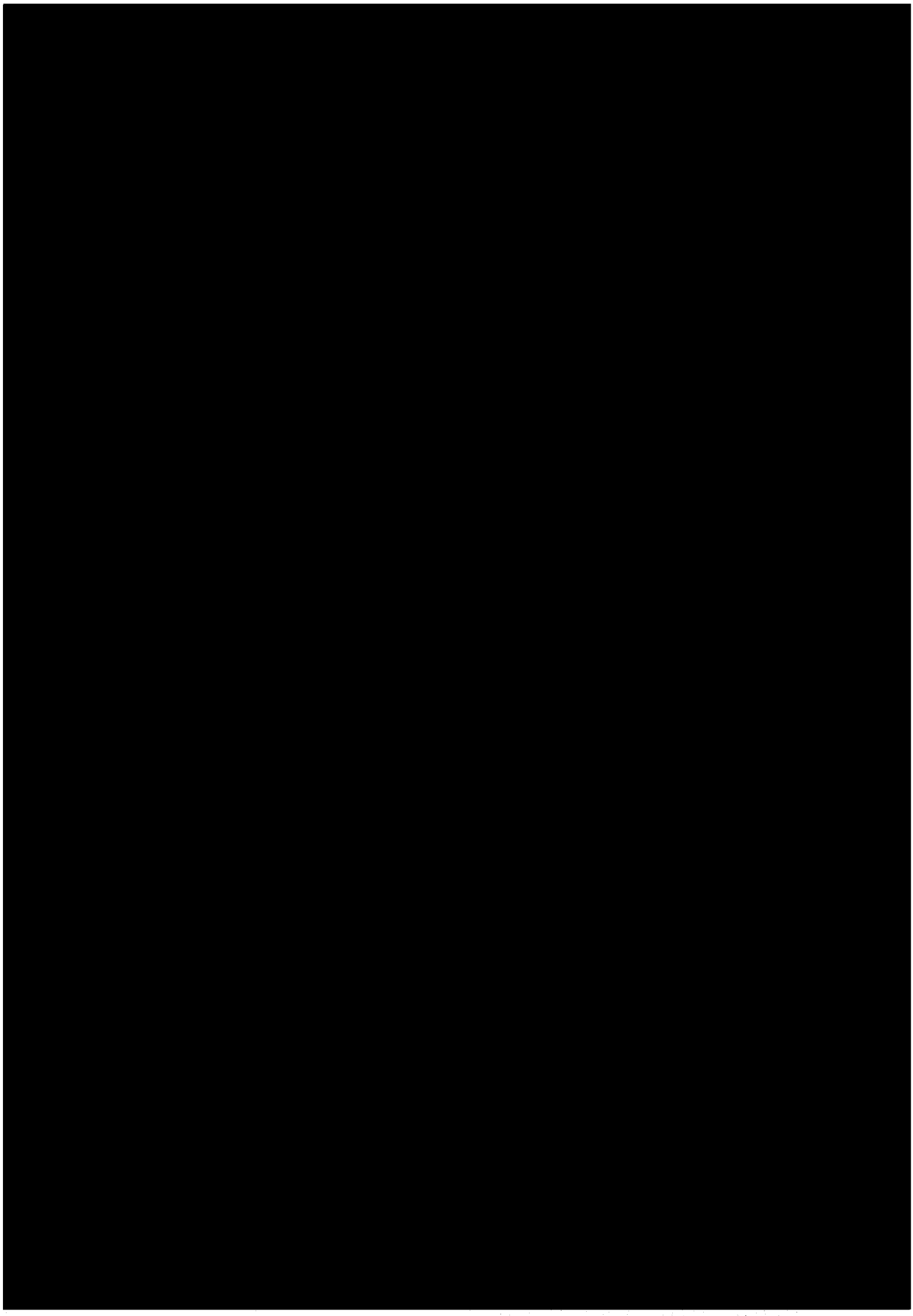

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Linda Quinn Code A

From: Offord, John Code A
Sent: 12 May 2003 09:31
To: GMC - Linda Quinn Code A
Subject: RE: Dr J A Barton

Dear Linda
The police are continuing their investigation into this matter, I will of course keep you fully updated regarding their investigation. The FFW solicitor in the case is Judith Chrystie.
regards
John

-----Original Message-----
From: Linda Quinn Code A
Sent: Friday, May 02, 2003 2:19 PM
To: Code A ; John Offord
Subject: Dr J A Barton

Hello

Just to let you know that I have inherited this case now that Michael Keegan has joined the Committee Development Team.

I have had a look at the latest correspondence and the PPC papers, and had a word with Michael. I understand that nothing is happening on the GMC case because we await the outcome of police investigations.

Please keep me updated!

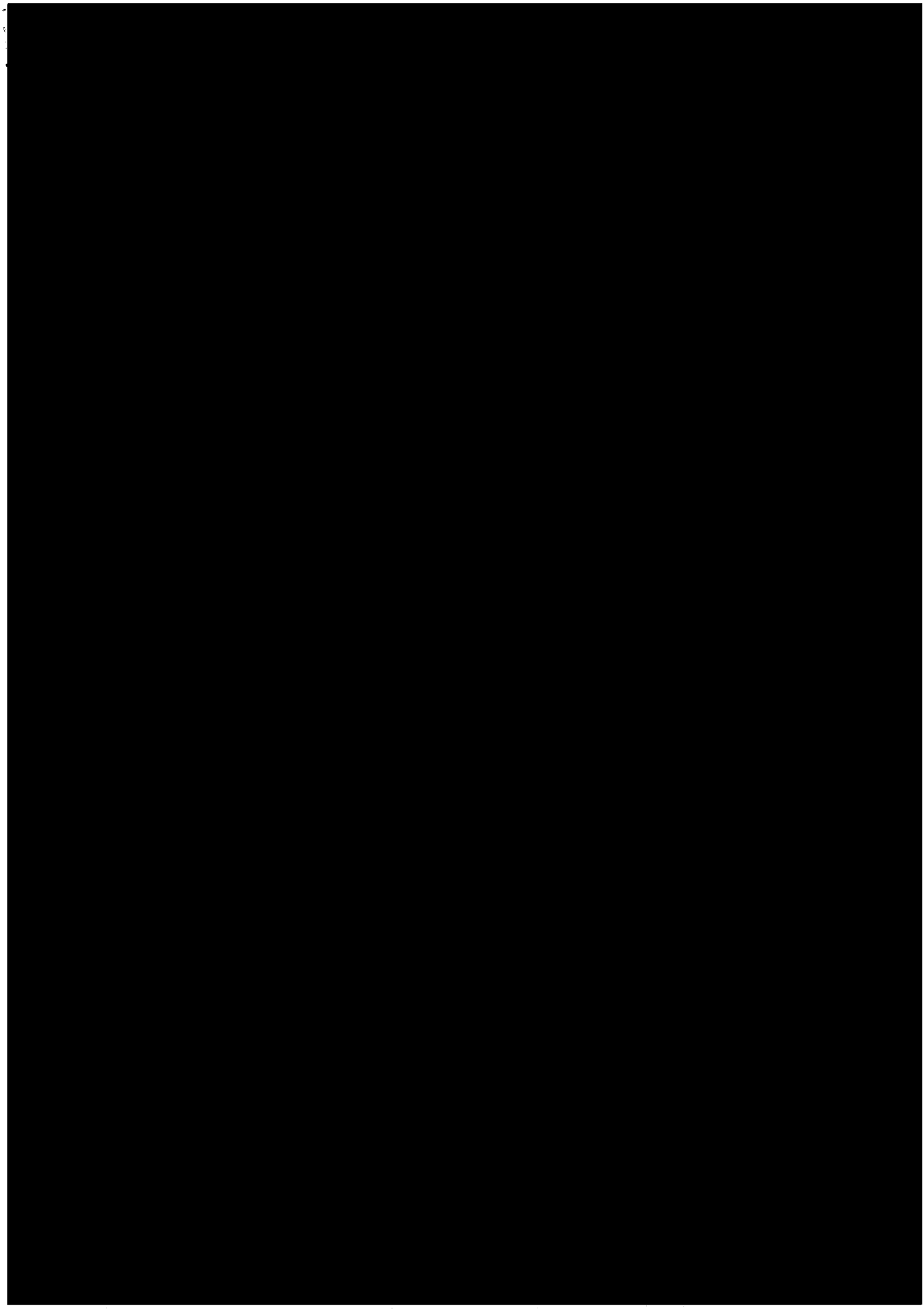
Linda

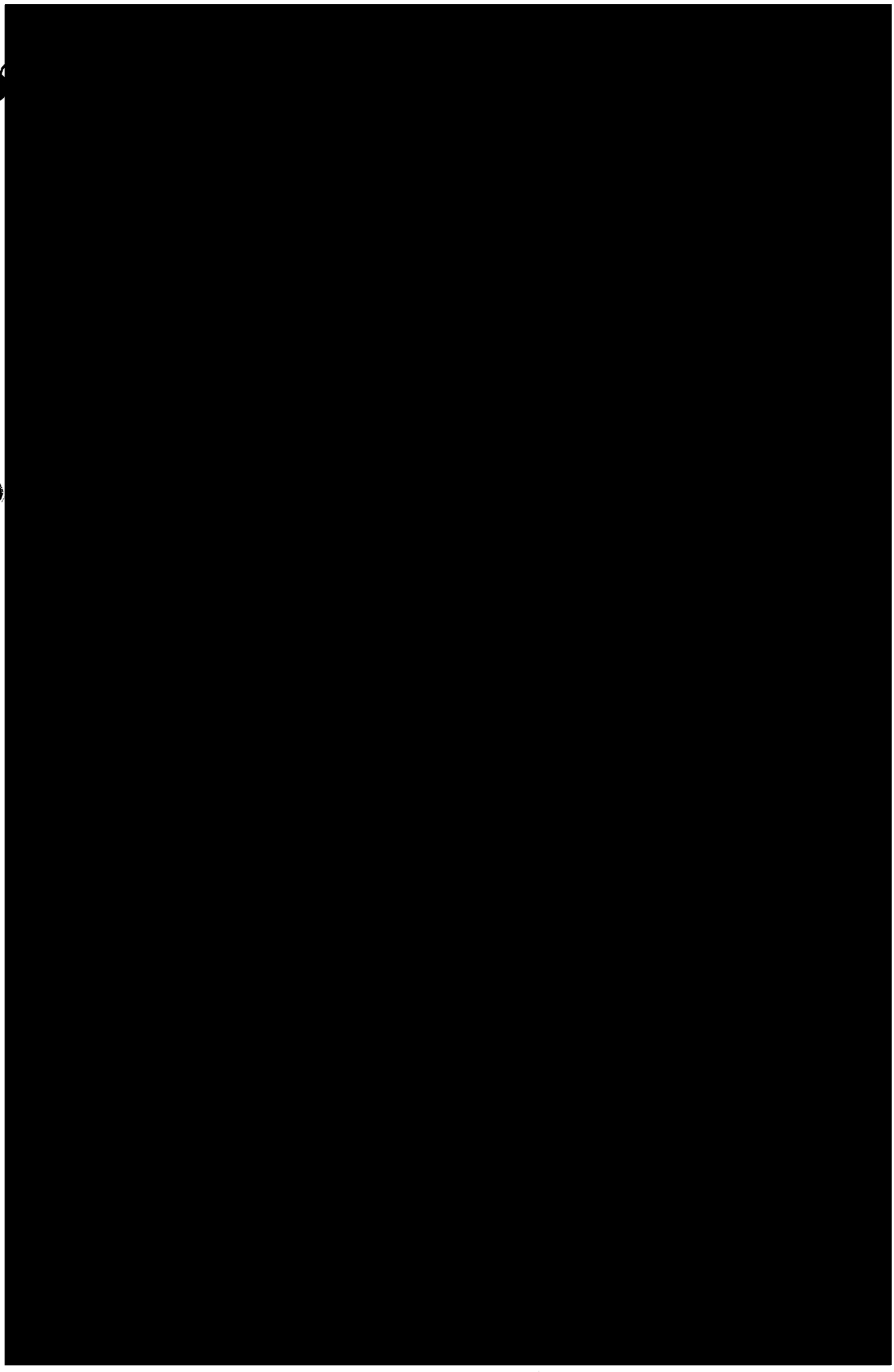
Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel: +44(0)207 861 4000
Fax: +44(0)207 488 0084
CDE: 823

[redacted]

[redacted]

17/04/2003





Meeting Note

	Judith Chrystie	Call type: **Meeting**	
Att:	**Hampshire Constabulary**	From:	
Duration:		Date:	**21 January 2003**

Dr Barton – Meeting with Hampshire Constabulary (Meeting No.2)

Attendees

FFW: Judith Chryste – JZC
Police: DI Nigel Niven – NN
DC Chris Yates – CY

Meeting

JZC thanking NN and CY for attending FFW's office in order to provide an update as to the progress on the criminal investigation since their meeting in November 2002.

NN advising that he was happy to do so and as he had reassured JZC in November, he would continue to do so. He wished to liaise with all stakeholders involved in the matter.

NN stating that the police investigation had expanded through to 1998-1989. This was the period in which Dr Barton had started undertaking work at the Gosport War Memorial Hospital (GWMH).

CHI Investigation

JZC advising NN and CY that she and JHO had recently visited the offices of the Commission of Health Improvement (CHI) in order to examine the documents and statements that had been taken by CHI during their investigation last year.

JZC advising that there was only one statement in which concern was raised regarding the prescribing habits of Dr Barton. This was a nurse who had initiated a grievance. JZC apologising for the fact that she did not have the documentation with her at the meeting but indicating that she would send her file note of analysis to Hampshire Constabulary.

JZC advising that there were a number of individuals that she wished to interview and she appreciated that she could not do this until the conclusion of the policy enquiry. Advising that she would, however, JZC indicating that she wished to obtain copies of the statements and documents relating to those interviews. JZC explaining that CHI did not want to pass on the statements without informing the witnesses that copies of the statements had been passed to the GMC. JZC commenting that CHI had, upon taking the statements, indicated that it might be necessary to pass those through to the GMC or the police and, consequently, CHI had already identified the possibility with each witness. JZC advising, however, that Julie Miller (of CHI), did wish to advise each individual that this had happened and JZC querying whether this would affect the police investigation.

NN stating that he was entirely "neutral" as to whether the witnesses were notified that their statements had been passed to the GMC. He felt that this was an entirely reasonable request particularly as JZC was confirming that she had no intention to approach the witnesses directly or take live evidence from any individual. JZC confirming that this was the position and advising that she would copy NN into any correspondence.

IOC Decision – Dr Barton's interpretation

JZC advising that she had seen a letter from Dr Barton to the Personnel Director of the Portsmouth Healthcare Trust. This letter contained comments regarding the IOC decision not to suspend or place conditions upon Dr Barton's registration prior to the PCC hearing. JZC advising that Dr Barton suggested that the IOC decision meant that the GMC's view was that there was no case to answer and, moreover, that the GMC did not consider that she has done anything wrong.

JZC stating that this was not the decision of the IOC hearing and she wished to obtain GMC instructions to write through to Dr Barton advising her that she could not continue to make such statements as this was not the position; the IOC had determined it was not in her interests nor the public interest to make an interim order but that the PCC would decide whether there was any criticism of her practice.

JZC querying whether, if the GMC provided her instructions to contact Dr Barton, this would have any impact upon the police enquiry. NN confirming that Hampshire Constabulary had made no efforts to conceal the fact that there was an investigation. The investigation of Dr Barton had been widely flagged up in the press. It was clear that the police were seeking to establish whether a crime had been committed and, if so, by whom. NN indicating that, from his perspective, he felt that it was only right and proper to notify her that it was inappropriate to make statements interpreting the IOC decision in this way.

NN commenting that it may be appropriate for the GMC to be able to write to Dr Barton and indicate that a police investigation was continuing and, therefore, the disciplinary action would not be

advanced until the conclusion of the criminal enquiry. JZC and NN discussion the fact that this would show that the GMC were not delaying matters unnecessarily and avoid potential arguments of abuse of process. In summary, it was clear that the GMC were holding disciplinary proceedings in abeyance whilst the police were undertaking their own enquiries.

Disclosure

JZC advising that there were a number of documents that she wished to pass through to the police. These documents related to the papers that had been considered by the PPC and the IOC. Advising that the GMC had the ability under Section 35A of the Medical Act 1983 (as amended) to pass on documentation to other parties in the public interest JZC indicating that the GMC were happy that it would be in the public interest to pass the documentation through to the police but were concerned that passing on documents such as the transcript of a private IOC hearing should be a document that was formally requested by Hampshire Constabulary.

JZC and NN discussing the fact that Hampshire Constabulary would be happy to make a formal request. NN asking JZC to ask him formally for those documents.

Police Investigation

NN advising that the police were investigating approximately 62 deaths. In each of these deaths it would be necessary for experts to analyse and review the medical notes. NN advising that in respect of the deaths, the families were involved and had expressed concern about the care their relatives had received.

NN stating that he was establishing a panel of experts to meet in the next few weeks. The panel of experts would be headed up by Professor Robert Forest. In addition, he would be joined by an expert in palliative care, geriatric care, general practice and epidemiology.

JZC was asked to check with the GMC as to whether Dr Barton had completed a palliative care course. JZC queried whether the GMC would have access to this information but indicating that she would ask the question. JZC advising that such courses may not be registerable matters.

NN stating that each of the experts would have access to the patient records. It may be that these were placed on CD to allow each expert to work remotely. He was, however, hopeful that a meeting could be arranged to allow all experts to discuss the case. He anticipated that the experts report may be completed in three/six months.

NN stating that the issue of causation was an issue which would be considered specifically by the experts. In addition, the experts would be asked to look at a mechanism for analysing the deaths on a medical and a scientific basis. NN stating that he wished to consider the statistical and mathematical basis for the significant number of deaths and for the experts to identify those deaths which cause concern from those that did not raise any issues for investigation.

NN indicating that there was a question as to whether it would be necessary to exhume any of the bodies. His current view was that exhumation was unlikely benefit the investigation but he wished his team of experts to confirm this point.

JZC querying whether the experts would be considering the appropriateness of the treatment. Stating that if there was no criminal basis for an investigation then, clearly, the GMC would be looking for the adequacy of the treatment regime. NN confirming that if he received evidence regarding any medical practitioner he would be obliged to disclose the material.

JZC advising that any expert report passed to the GMC prior to the conclusion of the criminal enquiries would lead to disclosure issues. JZC discussing the need to disclose evidence upon which the GMC wished to rely and, say, an IOC hearing. NN appreciated the disclosure issues and advising that he had to consider the key points of risk to patients when acting in the public interest. NN advising that he was aware of these issues and to the need to secure patient safety.

The police would then have to interview appropriate witnesses. He did, however, anticipate that, using 'due diligence', he did not anticipate the investigation taking 2-3 years as JZC had feared. NN advising that he hoped to have a clear idea about where the police investigation would be going by the end of 2003. He hoped to have completed his investigation and sought legal advice on the points. He was anxious to move as quickly as possible.

Family Solicitors

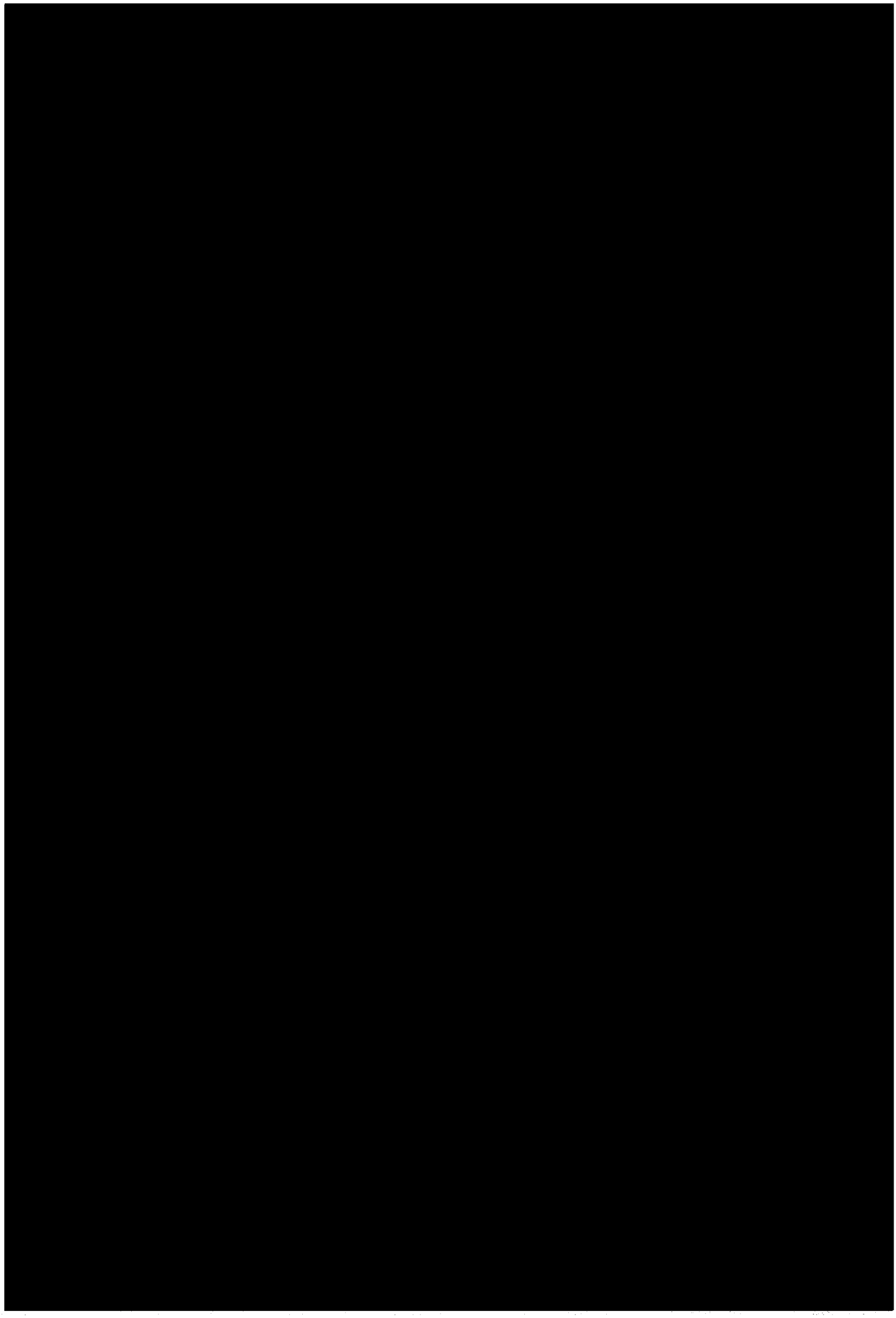
NN advising that he continued to have a good relationship with Ann Alexander of Alexander Harris who was acting for many of the families of the deceased relatives. He hoped that he would continue with such a relationship, it appeared that Ann Alexander shared the same view regarding rebuffed approached in any dealings with the media. Ann Alexander had indicated that she would not approach the media.

NN stating that he had a meeting with a family group on 5 February 2003. Alexander Harris and the other patient groups would be attending this matter which was designed as an open forum.

NN querying whether JZC would be happy for NN to mention that Hampshire Constabulary were liaising with the GMC on a regular basis and keeping them fully informed of the circumstances surrounding the investigation.

Conclusion

All parties confirming that the meeting had been useful as an updating exercise and reiterating their intention to continue to have regular meetings throughout the duration of the criminal enquiries.



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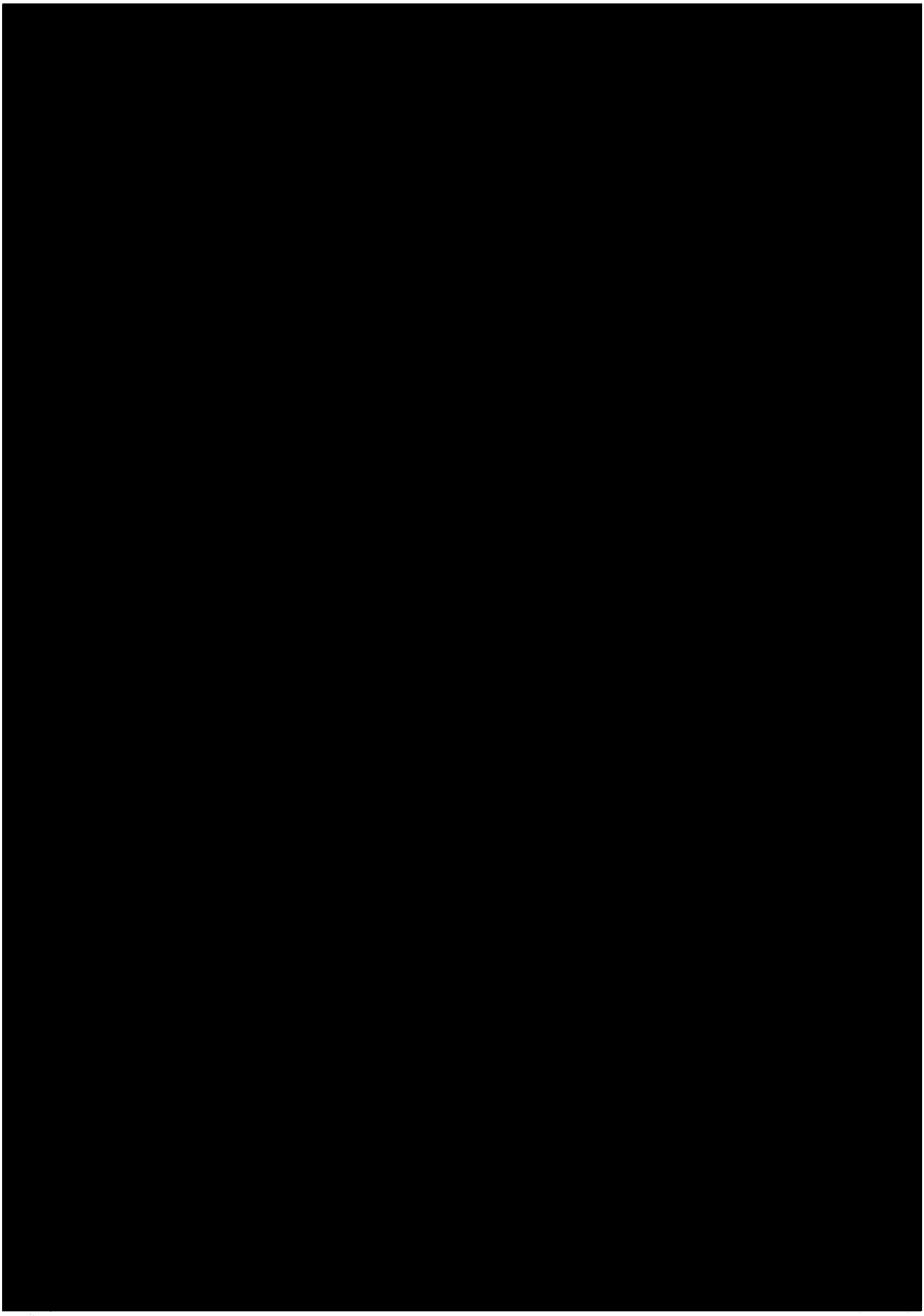

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FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Meeting note

Name: **Judith Chrystie**	Call type: **Meeting**
Duration:	Date: **20 November 2002**

Barton - Meeting with Hampshire Constabulary

Attendees:

GMC: Michael Keegan - MK

FFW: Judith Chrystie - JZC
John Offord - JHO

Police: DI Nigel Niven - NN
DC Owen Kenny - OK

Meeting

The attendees agreeing that JZC would make a brief minuted note of the meeting for circulation to all parties.

The parties introducing themselves and explaining their involvement in the case.

JZC explaining the situation within the GMC. Advising that the GMC would not proceed if NN indicated that to do so could prejudice any policy enquiry. JZC explaining the difference between running the case as a conviction matter and one in which we had to prove serious professional misconduct. JZC indicating the criminal rules of evidence were applied in GMC proceedings.

MK updating NN and OK as to the current position of the GMC enquiries. Indicating that the matter had both been screened and placed through the PPC.

JZC clarifying that the papers that the screener and the PPC had seen had been provided by Acting Detective Superintendent Burt. Noting that these papers had been forwarded through to the GMC when it appeared that the police were no longer pursuing any criminal investigation. NN advising that when, in 1998/1999 concern was raised by the death of Gladys Richards, an investigation had taken place which the police admitted was not as effective as it should have been. Advising that the CPS had considered the investigation and, in particular, the report prepared by Livesley on the Richard's case and had taken the view that causation could not be made out.

NN explaining that following the CPS's conclusion, the families of the elderly patients stated that they considered the police had been too quick to conclude the matter and that as a consequence four other cases were "dip sampled" by a new investigating officer, Detective Superintendent James. Those other cases were considered by two alternative experts Ford and Munday.

NN indicating that he was concerned about the issue of causation and whether proving causation may be just outside of the Constabulary's reach. Noting, however, that although the file had been prepared again for the CPS (by DI Stickler) and contained information on all five cases, there were a number of other incidents which still required full investigation. NN indicating that on statistical analysis and a similar fact basis it may be possible to establish causation. Noting that there were significant arguments about the appropriateness of the prescribing regime and the instructions left by clinical staff. The attendees noting that this was a particular issue for professional regulation given that it was not necessary to show that causation resulted in death merely of the inappropriateness of the prescribing regime amounted to bad practice.

NN advising that there were 50 other cases that the police may consider. One of the issues that would have to be resolved was whether a policy decision should be made to look at the hundreds of individuals who had died at the Gosport War Memorial Hospital. Noting that from 1994 to the period in which Dr Barton resigned from the hospital, there were thousands of deaths, 600 of which had been certified by Dr Barton. There were further cases in which Dr Barton had provided the care although the death may have been certified by a different practitioner.

Given the number of cases and the provisional views being provided by an alternative expert instructed by NN, Professor Robert Forest, NN stating that he was increasingly moving towards the view that he was entitled to argue that causation could be made out. NN noting, however, the difficulty in showing that death through bronchial illness of pneumonia was a consequence of diamorphine. Although it was noted that excessive diamorphine could cause respiratory difficulties, the victims were elderly patients who were, therefore, vulnerable in any event.

NN commenting that although there was a theme developing through the cases to suggest that Jane Barton had relied on diamorphine and syringe drivers, the police had to investigate the practices of the other practitioners working at Gosport Hospital. The attendees agreed that Jane Barton could not be seen to be persecuted alone.

JZC noting that the environment in which Dr Barton was working in which there were no prescribing policies may have allowed her to operate undetected.

OK identifying the fact that in 1991 concerns had been raised regarding the use of diamorphine by junior nurses. MK and JZC advising OK that these papers had been provided to the GMC but did not take the matter further in terms of the interim procedures. OK advising the circumstances in which the concerns had been made by the junior nurses and the fact that the medical practitioners and senior nurses had been opposed to any questioning of the clinical decision making. Noting that the fact that concerns had been raised some years previously did suggest that there was something amiss with James Barton's practice over a period of years.

NN noting that there appeared to be a lack of motive. OK was continuing to look at this element.

NN advising that Liam Donaldson had asked Professor Baker to consider the issues raised by the cases identified by the police. NN had persuaded Professor Baker to also expand his enquiries into Dr Barton's GP practice. NN noting that Professor Baker's analysis of the statistics would take some time.

JZC advising that the GMC had the power to make an interim order suspending or placing conditions upon a medical practitioner's registration notwithstanding the fact that he or she had not been found guilty of serious professional misconduct. Stating that in this instance the IOC had determined not to place any interim order upon Dr Barton's registration. Noting that this was based on a convincing argument by Dr Barton explaining the lack of resources and supervision and the poor conditions under which she had had to work. Stating that given that the police were suggesting that there was potentially hundreds of deaths caused by Dr Barton and were actively assessing whether a murder charge could be prosecuted, JZC would be concerned to protect the patients and the public interest by presenting new evidence to an IOC Panel.

The parties discussing the disclosure requirements for GMC. Noting that the GMC would be forced to disclose any document which they wished to present to an IOC hearing in reliance of a request for an interim order.

NN appreciating the vulnerability of the GMC to criticism if a patient was killed at the hands of Dr Barton when the GMC could have taken action to prevent her from practising. He was, however, concerned regarding disclosure of material which he would not wish revealed to the doctor at too early a stage. NN stating that it would possible for him to write a letter for the GMC indicating that police investigations were continuing and that there were a minimum of 50 patients whose deaths would be analysed. The letter could also advise that early medical advice suggested that the deaths had been hastened by the prescribing regime provided by Dr Barton. The attendees agreeing that the letter from NN would also formally request that the GMC state their proceedings.

JZC expressing concern that the defence could argue that Dr Barton was no longer working at Gosport War Memorial Hospital and, therefore, patients were not at risk from diamorphine prescriptions or syringe drivers. OK noting in this regard that Dr Barton's private practice would include elderly patients. JZC commenting that although she appreciated that it had not yet been determined whether the criminal enquiry should consider the private/GP practice, it would be helpful if the fact that investigations may be expanded in this direction could be included within the letter to the GMC. NN stating that whilst he would wish to assist the GMC as far as possible, it may be

difficult for him to add this element to any letter. Noting that Professor Baker had agreed to expand his analysis to include Barton's private practise, but this was not part of his specific remit established by Liam Donaldson.

NN advising that the letter to the GMC would also formally establish the Constabulary's commitment to liaise closely with the GMC. The parties agreeing that formal letters would be written outlining information that was possible for the GMC to disclose. There would also be contact through e-mail, telephone and further meetings. JZC advising that she was likely to phone NN on a monthly basis so that she could report back to the GMC in her monthly reports!

The parties noting that Alexander Harris had expressed concern that the individuals involved in the various investigations and enquiries were not liaising. Noting the commitment to liaise closely could be articulated to Ann Alexander at Alexander Harris - it would, however, be necessary to stress the different role that each of the particular stakeholders were bound to adopt. Detail would not be provided about the level of communication or the information being passed between the parties but Alexander Harris should be advised that formal channels of communication had been developed.

In this regard, NN advising that he had met with Ann Alexander last week. The meeting had been productive in that it had been on a non-adversarial basis. Stating that Ann Alexander had used the media to generate publicity for her firm following the meeting, however, formal channels of communication had been established and it had been agreed that the family could raise concerns regarding any police investigation through Alexander Harris. Hampshire Constabulary had also agreed to advise any new individuals that Alexander Harris were acting for relatives; NN stressing that this would not be a referral service but merely informative.

NN stating that an important date was his meeting with the CPS scheduled for 28 November 2002. This meeting would establish the Constabulary's expectations as to the speed with which the CPS should consider the papers. NN advising that if the CPS did not consider the matter should proceed to a prosecution, the case could be considered by Treasury Counsel (an alternative Treasury Counsel from that which considered the initial referral of the Richard's case).

OK querying whether the GMC had any record of Dr Barton's qualifications as he did not have a full history or CV. The GMC would attempt to track down as much information as possible.

The GMC also would pass on any Rule 6 response letter if appropriate. JZC also advising that the GMC had received two other complaints Carby and Batson. NN and OK did not recognise these names as individuals within the 50 cases being investigated by the Constabulary. JZC to pass the documents through to the Constabulary.

There appeared to be a culture of resorting to diamorphine care too quickly (perhaps for a easy life?). The parties identified the fact that there may be problems with other doctors. MK advising NN and OK that the case against Lord had been "screened" within the GMC procedures and a decision taken not to pursue the matter.

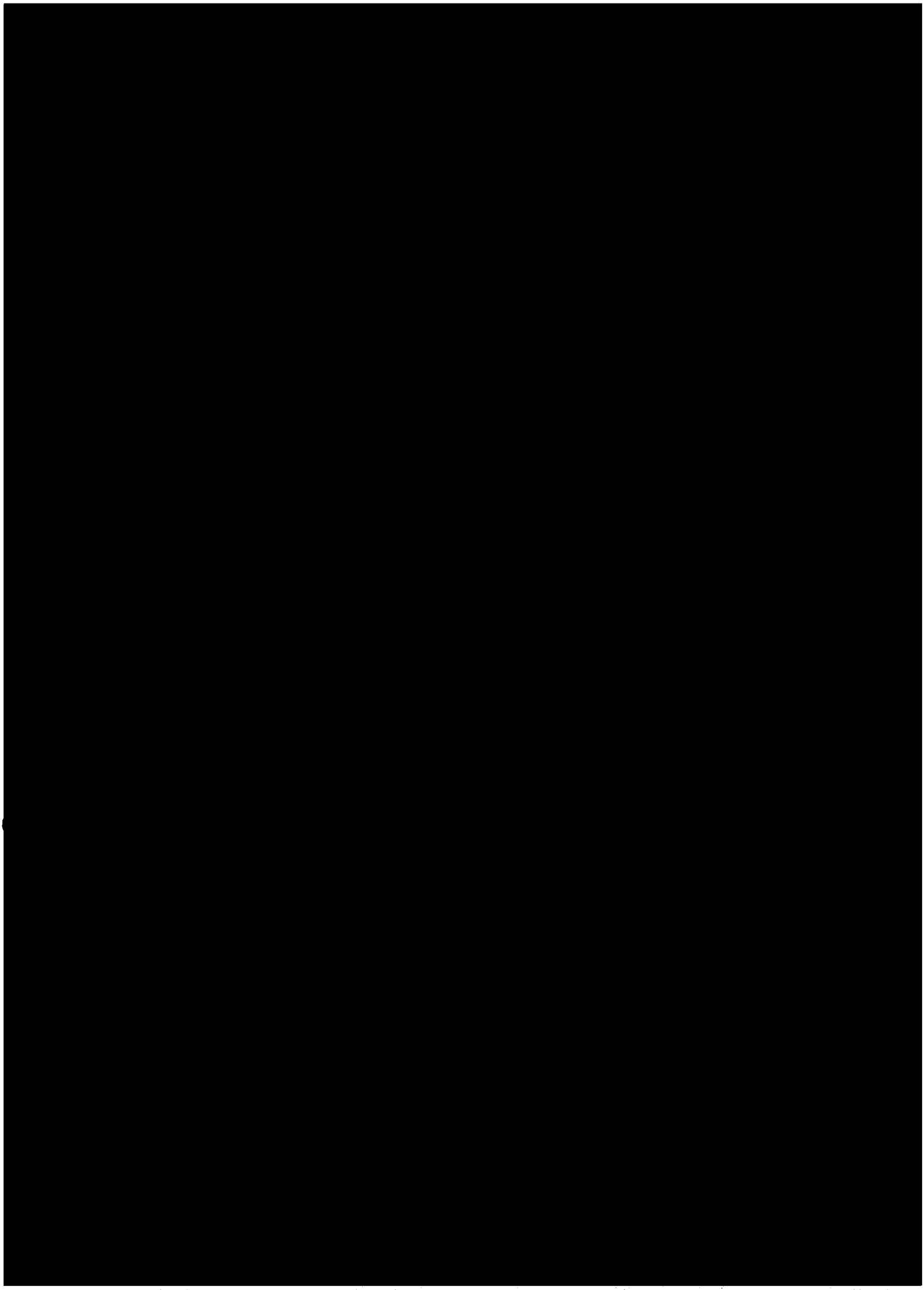
As regards disclosure, JZC stating that she would work on the assumption that any documents provided by the police would be undisclosable unless she was specifically advised otherwise in writing. JZC stating that the GMC enquiry, once it was permitted to proceed would, of course, have to disclose any documentation passed through by the police. NN and OK appreciating this fact and noting that at that stage, in any event, the policy enquiry would be concluded. NN stating that once the police enquiry was concluded it would be possible to pass JZC all relevant documentation and, indeed, this was the basis on which the police worked.

JZC explaining that we had received a report from CHI. She explained that we wished to obtain the documents that had been considered by the CHI investigation team and, moreover, visit CHI in order to analyse the witness statements taken. Stating that there would be no intention to interview the witnesses. NN agreeing that this would not prejudice any police investigation and JZC and JHO could proceed with this aspect of the GMC enquiry.

The parties summarising the fact that NN would provide a letter to the GMC which could be used by the GMC in an IOC hearing, which would formally ask the GMC to stay their investigations and which would state that the parties were committed to regular liaison. (JZC and MK noting that it may be difficult to persuade an IOC panel to place an interim order based only on a letter but identifying that this was the best position). NN advising that the police would advise the GMC of any significant event and would release information if it was appropriate for them to do so.

[redacted]

[redacted]



Your reference: JZC/HJA/00492-14742/2145525v1
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

7 January, 2003

Ms Judith Chrytie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

Dr Jane Barton

At Ian Barker's request I have written to him to confirm that the provisional date for the Professional Conduct Committee, namely 7 April 2003, will not now be used, owing to the ongoing police inquiries. He has stood down counsel accordingly.

I have still not received the attendance notes of the meetings on 3 October or 20 November 2002. I also await confirmation of the time of our meeting scheduled for 22 January; may I suggest 14:00? I am happy to attend your offices.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your reference: ISPB/TOC/0005940/Legal
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

7 January, 2003

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

Dear Mr Barker

RE: DR JANE ANN BARTON

Further to our telephone conversation I write to confirm that the provisional date for the Professional Conduct Committee, namely 7 April 2003, will not now be used. You indicated that you were to stand down counsel on this basis.

We cannot, as you know, proceed to public inquiry while police investigations are ongoing. I am advised that those investigations are not likely to be concluded in the immediate future. It does not appear, therefore, that the PCC will be able to consider this case in the early part of next year, as we had hoped.

I trust that you will continue to liaise with Messrs Field Fisher Waterhouse and us, as appropriate.

Yours sincerely

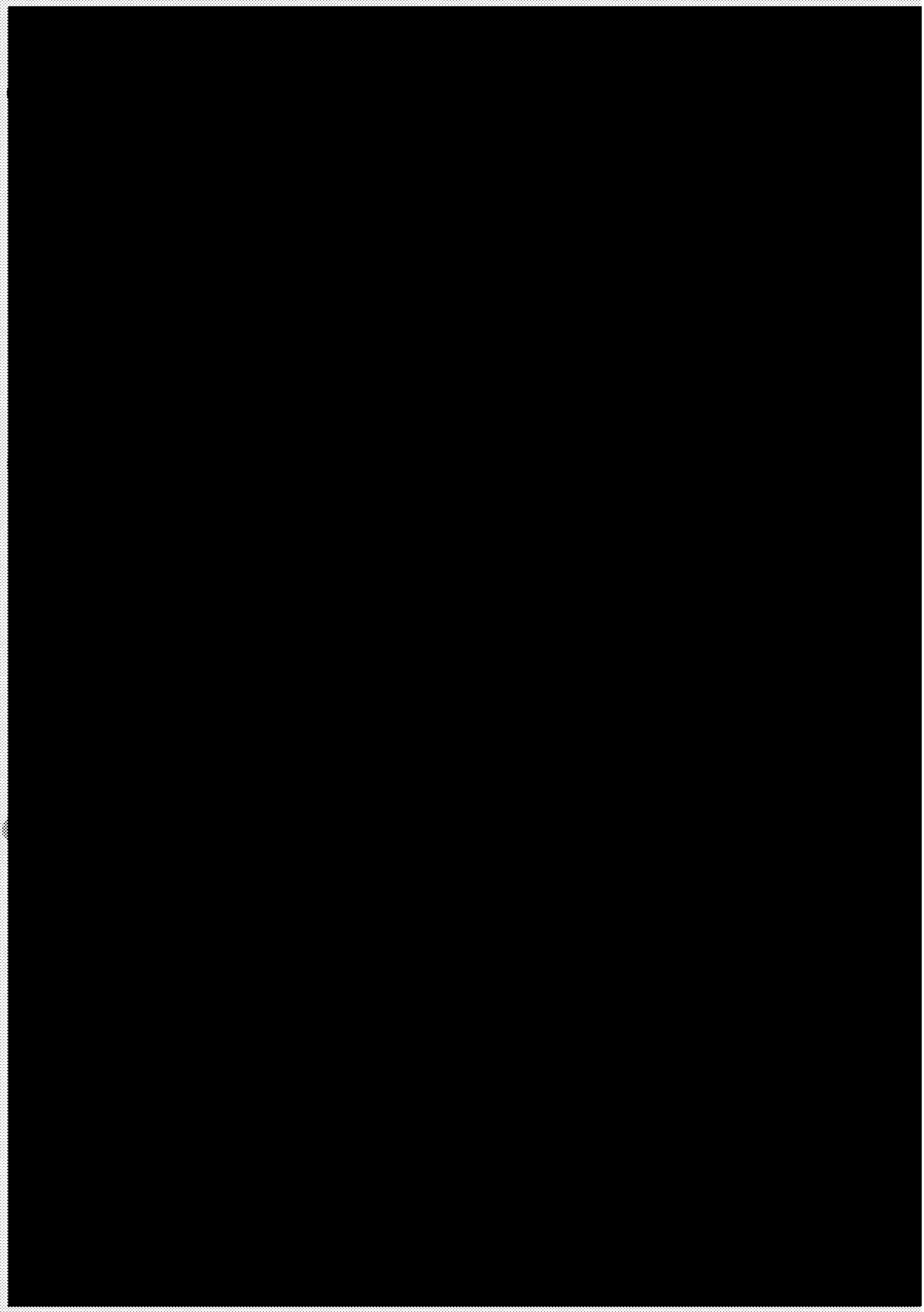
Code A

Michael Keegan
Conduct Case Presentation Section

Code A

[redacted]

[redacted]



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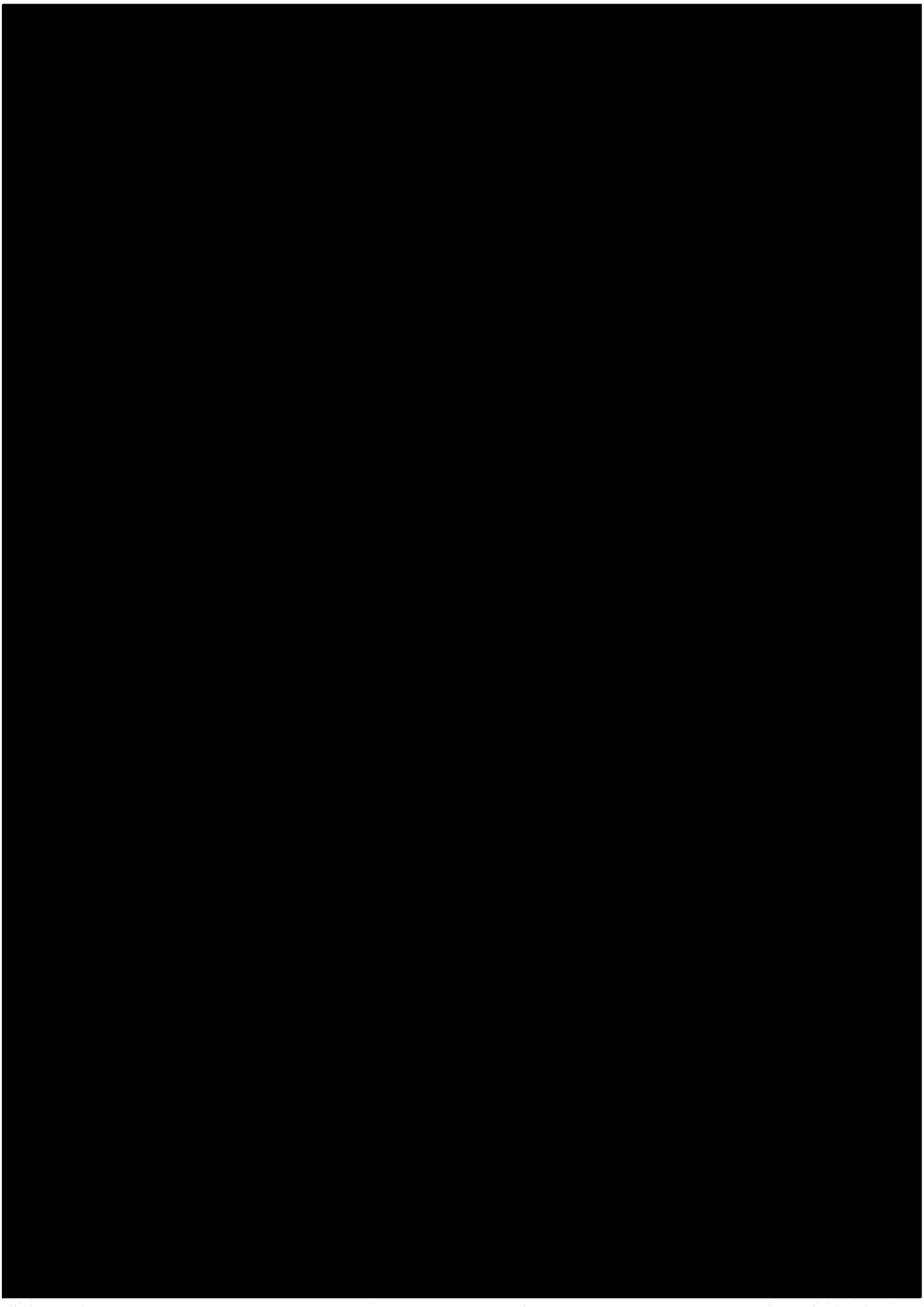


HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Tel. 0845 04554545
Fax. 023 80599838

RECEIVED
-4 DEC 2002

Our Ref. Operation Rochester

Your Ref.

2nd December 2002

Judith Chrystie
Field Fisher Waterhouse
35 Vine Street
London
EC3N 2AA

Dear Judith

Re Operation Rochester – Gosp

You will recall that on the 20th [redacted] our offices in Vine Street. At th[redacted] our investigation into certain [redacted]

You indicated to us th[redacted] quiry in respect of the professional conduct [redacted] a hearing may take place in April 2003 in resp[redacted] ou further indicated that in the event of the po[redacted] tion into the same circumstances, that those proceedings [redacted] come of the police investigation was known.

I was able to inform you that our investigation was [redacted] nd likely to take some duration and certainly not be concluded before April 2003. I also [redacted] icated that the police were due to have a meeting with the Crown Prosecution Service on the 28th November 2002 and that the extent of the police investigation would not be clear until after that meeting.

I am now able to tell you that the arranged meeting with the CPS took place. It was agreed on the basis of what was discussed to continue and expand the investigation. I have been asked by the Senior Investigating Officer, Detective Chief Superintendent Steve Watts, to notify you of this fact and to formally ask you to consider pending the anticipated hearing in April until further notice.

Within the usual accepted restraints, I will undertake to keep you appraised of developments. Whereas our roles within this matter are quite clearly and quite rightly different, it can only be in the interest of justice and the public that we continue to liaise wherever appropriate.

If I can assist you any further, please do not hesitate to contact me.

Yours sincerely

Code A

Nigel Niven
Detective Inspector 7445
Major Crime Investigation Team

Michael Keegan Code A

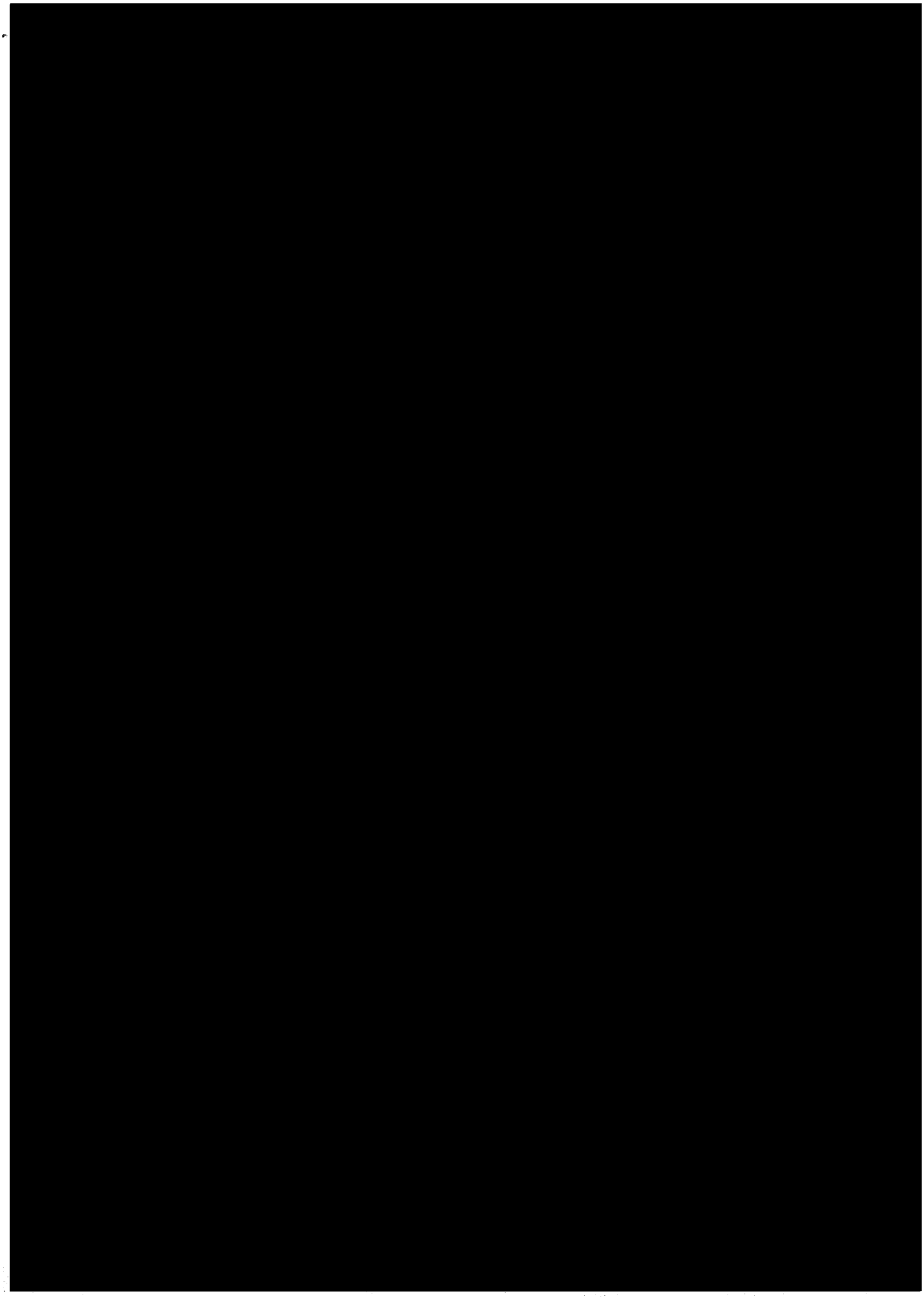
From: Michael Keegan Code A
Sent: 07 Nov 2002 13:01
To: Code A
Subject: Dr Barton

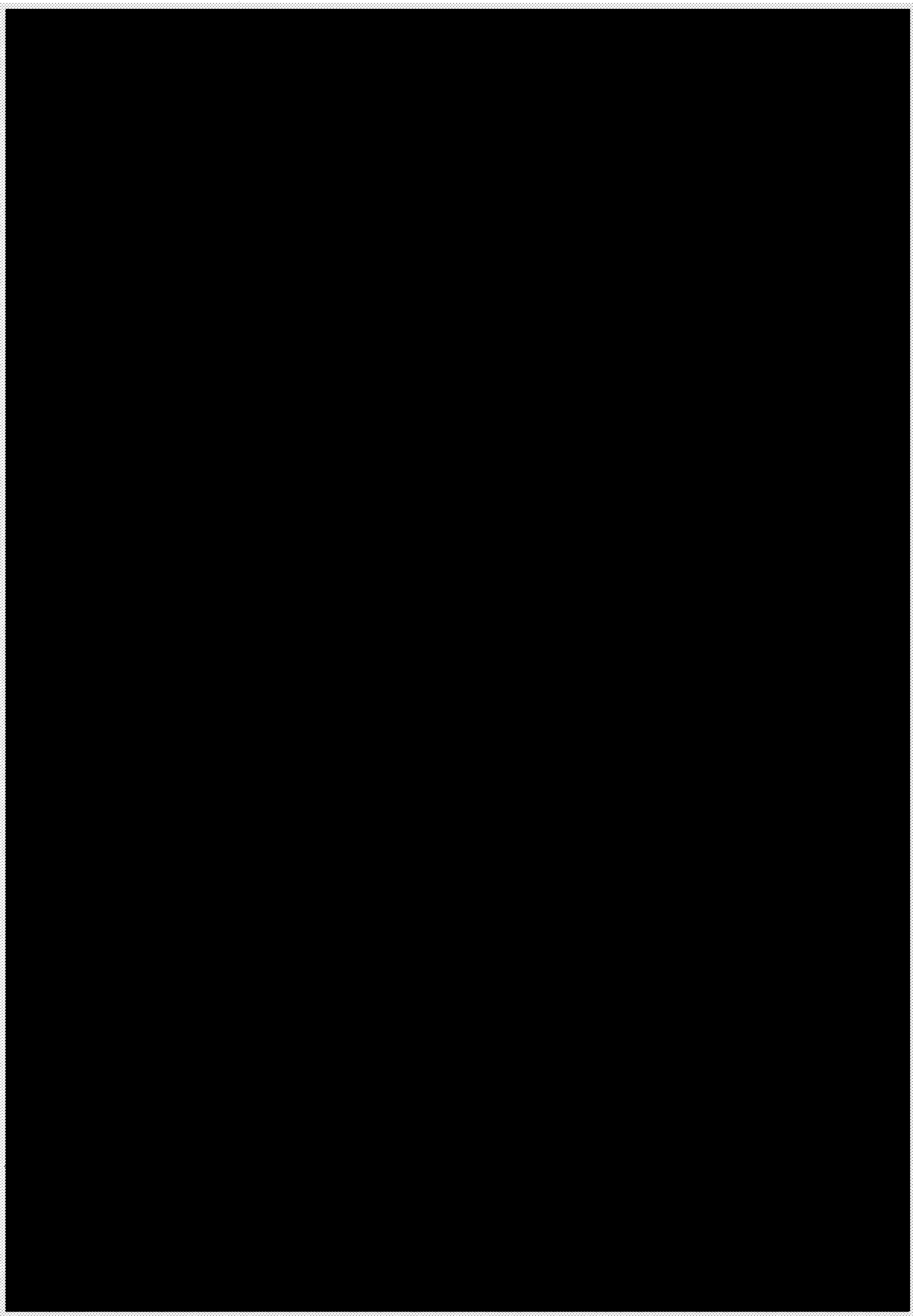
Judith,

I have been informed by my colleage, Michael Hudspith in Screening, that a complaint about Dr Lord, Consultant at the Gosport War Memorial Hospital, has recently been closed.

Michael Keegan
Conduct Case Presentation Section

Code A





TRANSMISSION VERIFICATION REPORT

TIME : 22/10/2002 12:55
NAME : GMC
FAX : Code A
TEL :

DATE,TIME	22/10 12:55
FAX NO./NAME	Code A
DURATION	00:00:32
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

Fax

To Judith Chritie

Fax number Code A

From Michael Keegan

Direct Dial Code A

Direct fax

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

No. of pages (inclusive) 2 *Time* 13:00 *Date* 22 October 2002

Dear Judith

RE: DR BARTON

Please find attached letter dated 16 October 2002 from Hampshire Constabulary, which is self-explanatory.

I should be grateful if you would let me know when you manage to arrange for us to meet with the appropriate officer/s.

Michael Keegan
Conduct Case Presentation Section
Code A

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Our Ref.

Your Ref.

Tel. 0845 04554545
Fax. 023 80599838

16th October 2002

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Dear Mr Keegan,

Thank you for your letter to Chief Superintendent James dated 17th September 2002.

This letter is to inform you that Detective Chief Superintendent Watts, has now been appointed the Senior Investigating Officer into matters relating to Gosport War Memorial Hospital.

The enquiry is being co-ordinated by myself, Detective Chief Inspector Robert Duncan of the Major Crime Team, 12-18 Hulse Road, Southampton, S015 2JX. My direct telephone number is:-

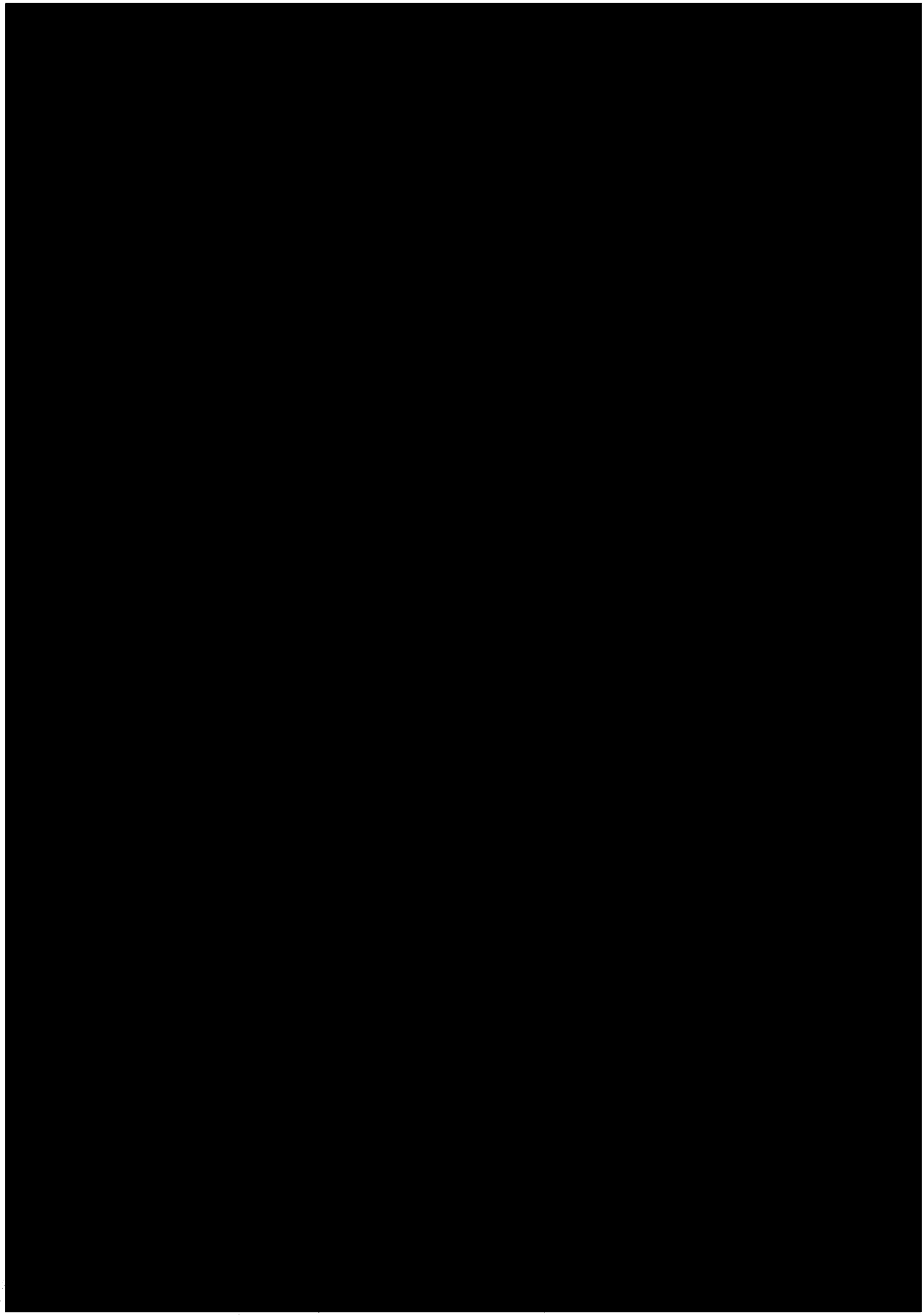
Code A

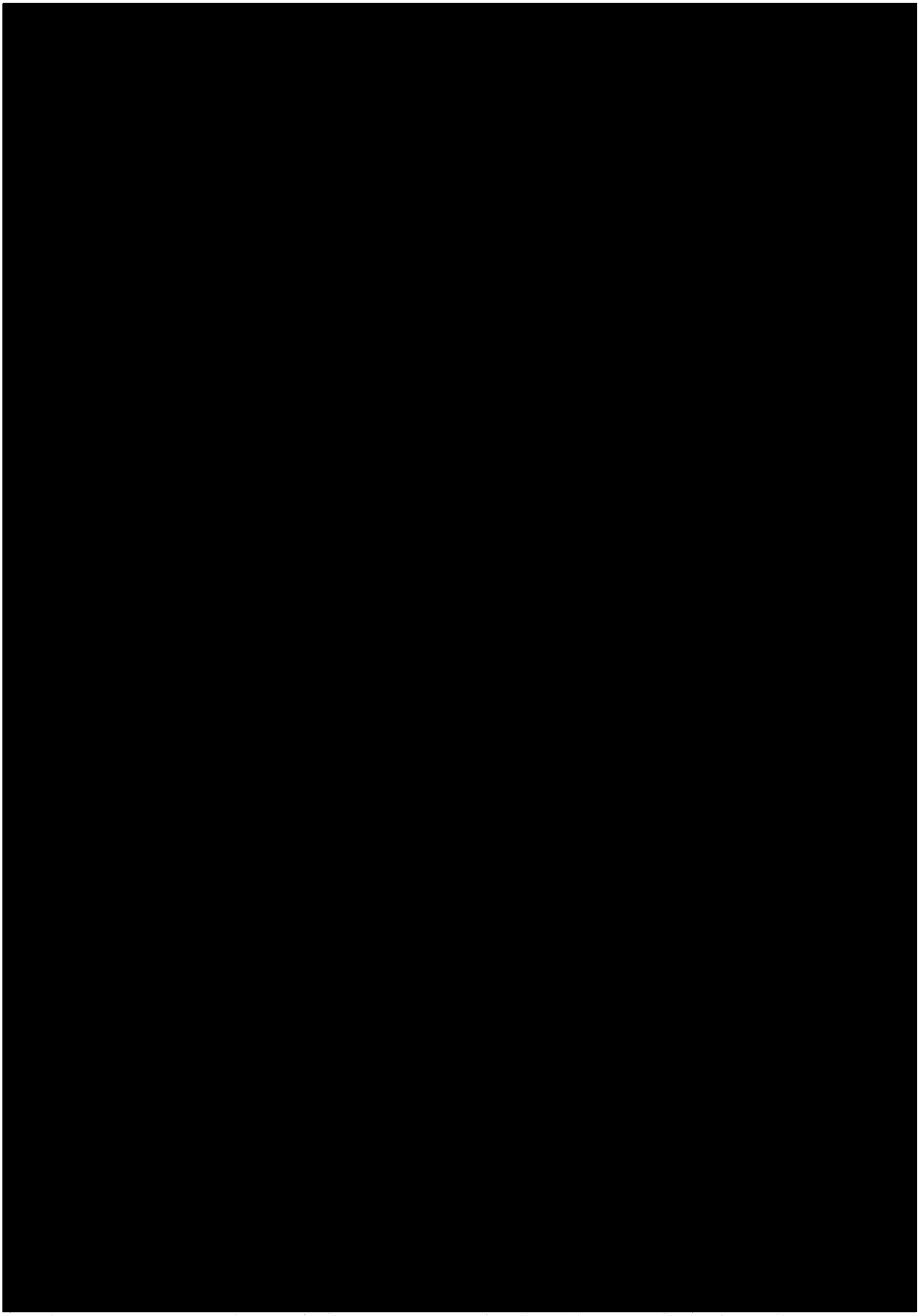
If I can be of any further assistance please contact me on the above number.

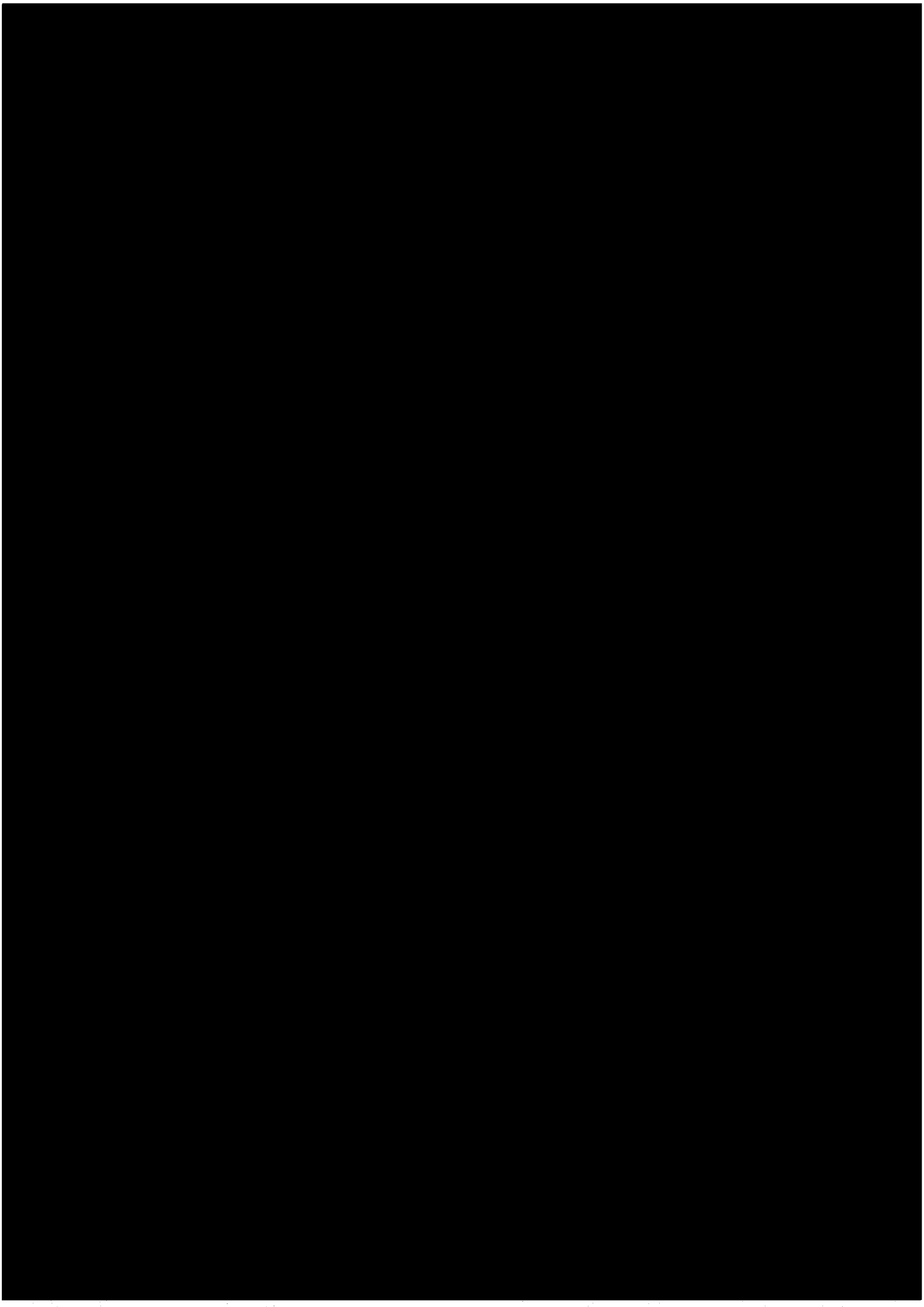
Yours sincerely

Code A

Robert Duncan
Detective Chief Inspector
Major Crime Investigation Team







DOES NOT INCLUDE - VOLUNTEERS -

Summary of Stakeholder details who had Negative experiences

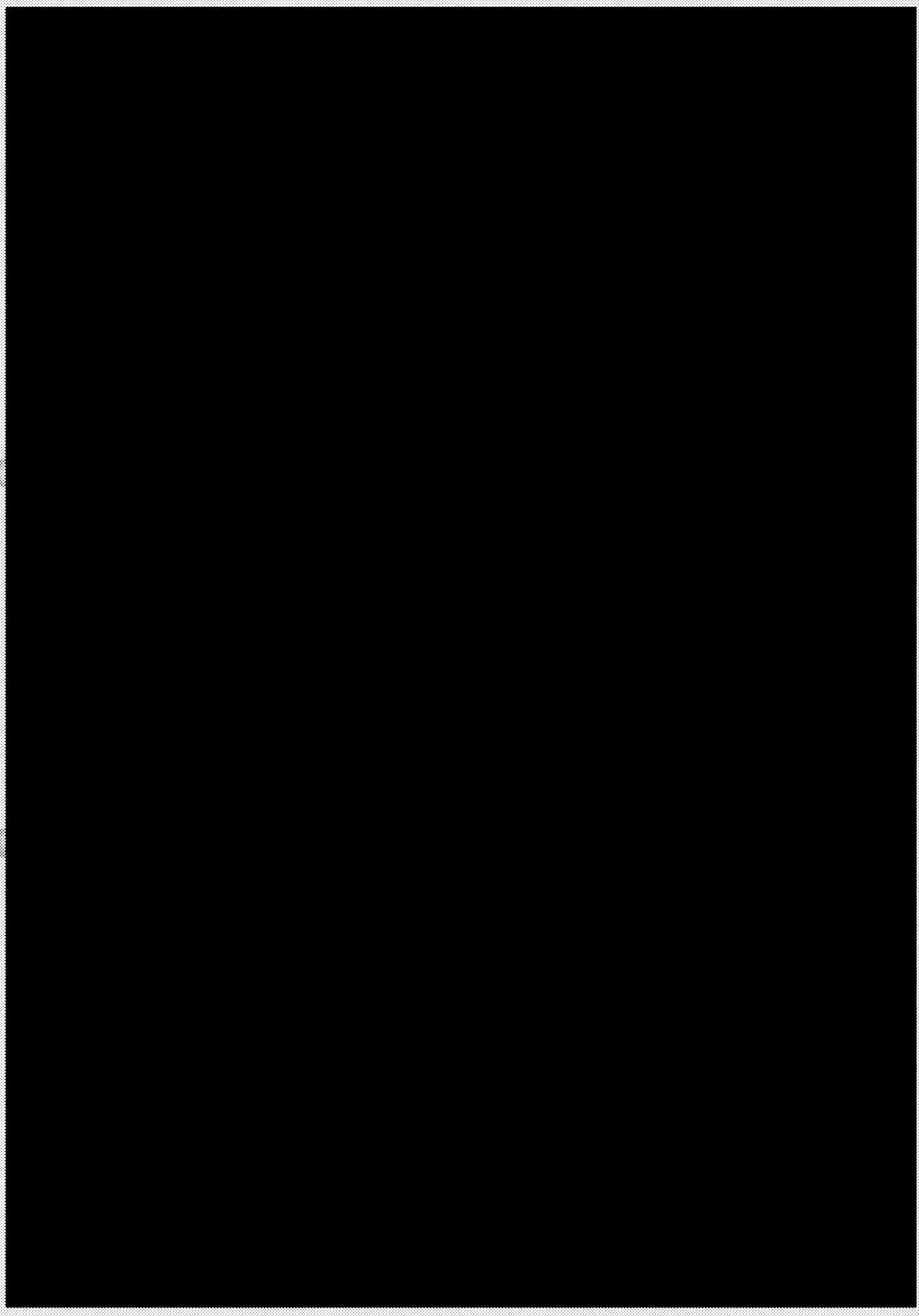
Wednesday 21 Nov 2002- Gosport	Thursday 22nd November- Portsmouth	Telephone Interviews
Mrs Ripley **Relative:** Mr Ripley (husband) **Ward:** **Partic:** Nearly killed husband. The husband had verybad arthritis and gout and Mrs Ripley feel they nearly gave him an overdose. An official compliant was issued but received a half hearted apology.	Mr J Pitthard & MR ALDROYD . **Relative:** Mr Nat Gonella (friend deceased) **Ward:** One of the Three **Partic** Very upset about the death of Mr Gonella three years ago.	Mrs Jackson **Relative:** Alice Wilkes (mother deceased) **Ward:** Deadalus **Partic** Mrs Richards & Mrs McKenzie **Relative:** Gladys Rochards (deceased) **Ward:** Daedauls **Partic**
Mrs Bulbeck **Relative:** Mother (Deceased) **Ward:** Daedalus **Partic:**	Mrs Deedman and Bereavement Councillor **Relative:** Mr Deedman (Husband Deceased) **Ward:** Daedalus . **Partic**	Mr Tim Welstead **Relative:** Father (deceased) **Ward:** Mulberry Ward **Partic**
Mr Page **Relative:** Eva Page (mother deceased) **Ward:** Daedalus. **Partic:**	**Friday 23rd November – Portsmouth** Mr Ian Wilson **Relative:** Father (deceased) **Ward:** Daedalus/ Lloyd . **Partic**	Mrs Blackwell **Relative:** Husband **Ward:** Collingwood **Partic** Code A **Relative:** Elsie Devine (mother) **Ward:** Daedalus **Partic**

Mrs Grahame **Relative:** Mr Grahme (Husband deceased) **Ward:** **Partic:** Concerned about treatment and death of her husband.	Mr Mitchell and Ms Wendy Mitchell **Relative:** Mr Mitchell (Father deceased) **Ward:** one of the three **Partic**	Mrs Bright **Relative:** Mother **Ward:** Daedalus **Partic**
Mr Wilson **Relative:** Edna Purnell (mother deceased) **Ward:** Daedalus **Partic:** Care and administration of diamorphine	Mr Abery **Relative:** Wife **Ward:** Dryad and Deadulus **Partic** On the Dryad ward the Staff Nurse interfered with drugs Q+A reduced prescription drugs by two thirds Deadulas did increase prescription but still effected wife.	Mrs Lovejoy **Relative:** Husband **Ward:** Collingwood **Partic** Sheena Windsor **Relative:** Norma Wilson (Mother deceased) **Ward:** Sultan **Partic**

Stakeholder with Positive experiences

Allan Smith-	Wife and himself	Mrs Purvis	Mother
R.E Brewster	Husband	Mr Nelson	Husband and Mother
Anon	Husband	Mrs Lesley	Husband
F Chase	Husband	Mrs Tryell	Mother and herself
H M Ord	Brother –in Law	Mrs Fitzpatric	friend

[redacted]



Your reference:
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

4 October 2002

Ms Judith Chrittie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

RE: DR JANE ANN BARTON

Further to yesterday's case conference, please find enclosed a copy of the CHI report and my letter to Ms Miller at CHI requesting the background information.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Fax

To Judith Chritie
Messrs Field Fisher Waterhouse

Fax number Code A

From Michael Keegan

Direct Dial Code A

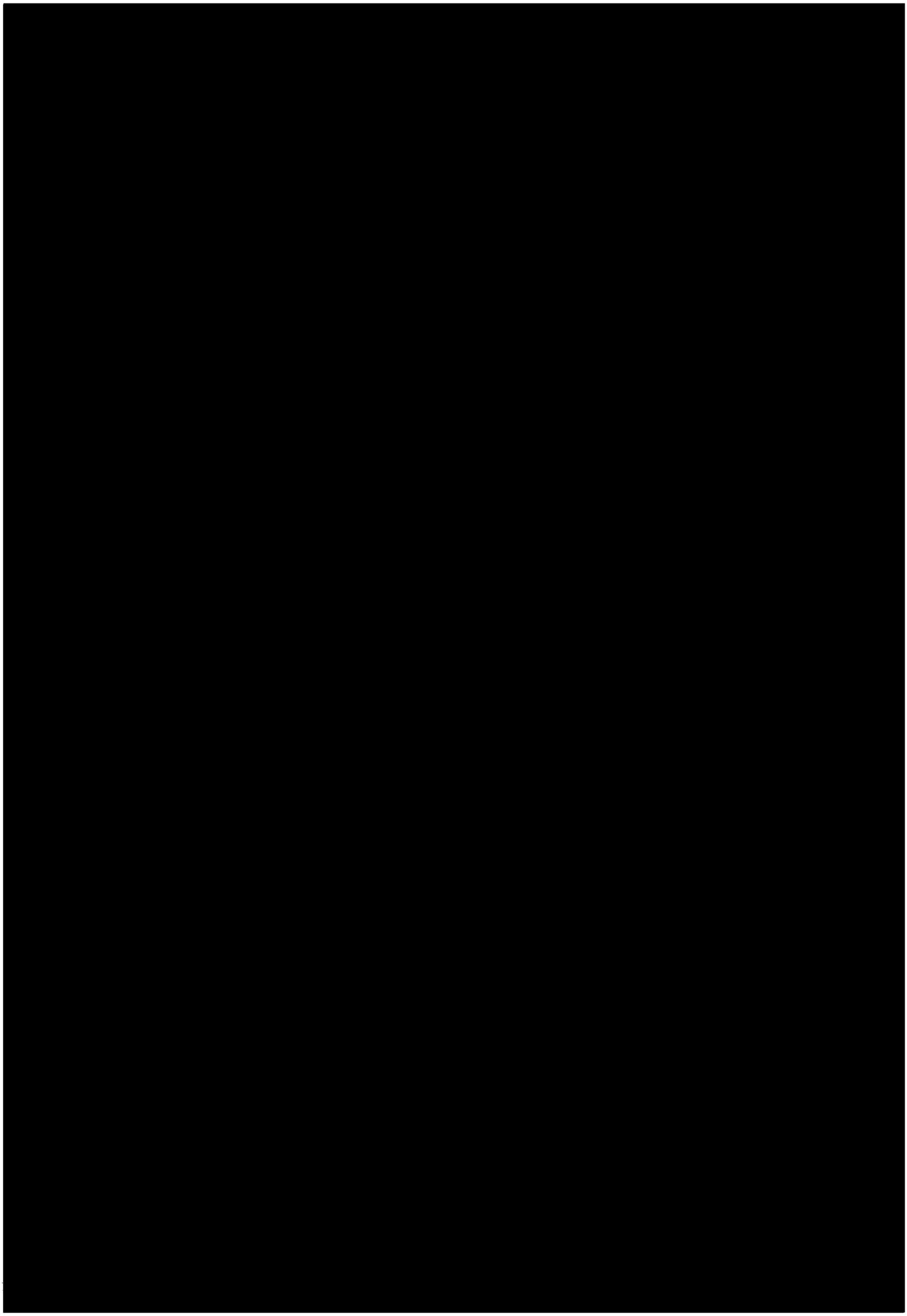
Direct fax

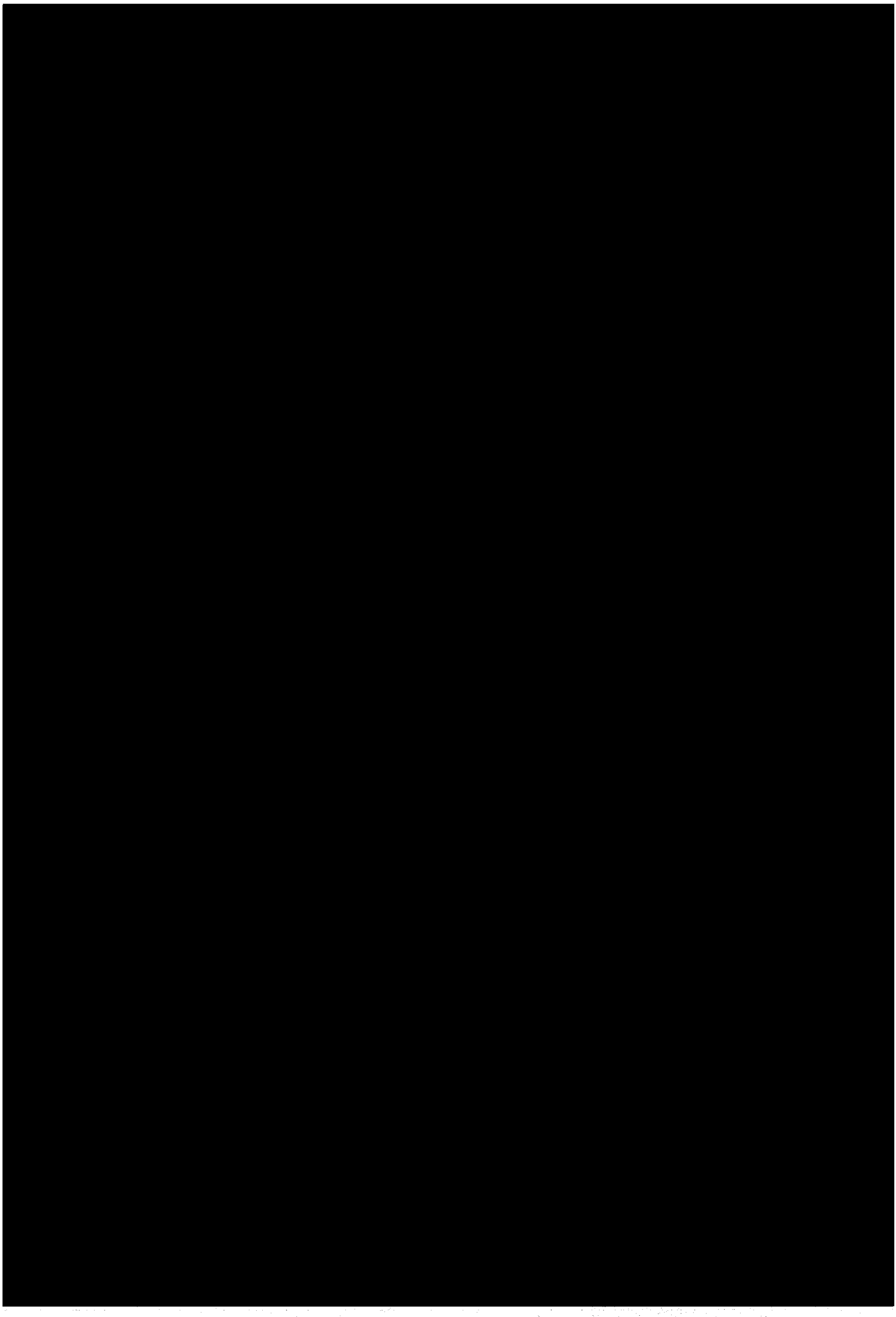
No. of pages (inclusive) 29 12:20 Date 3 October 2002

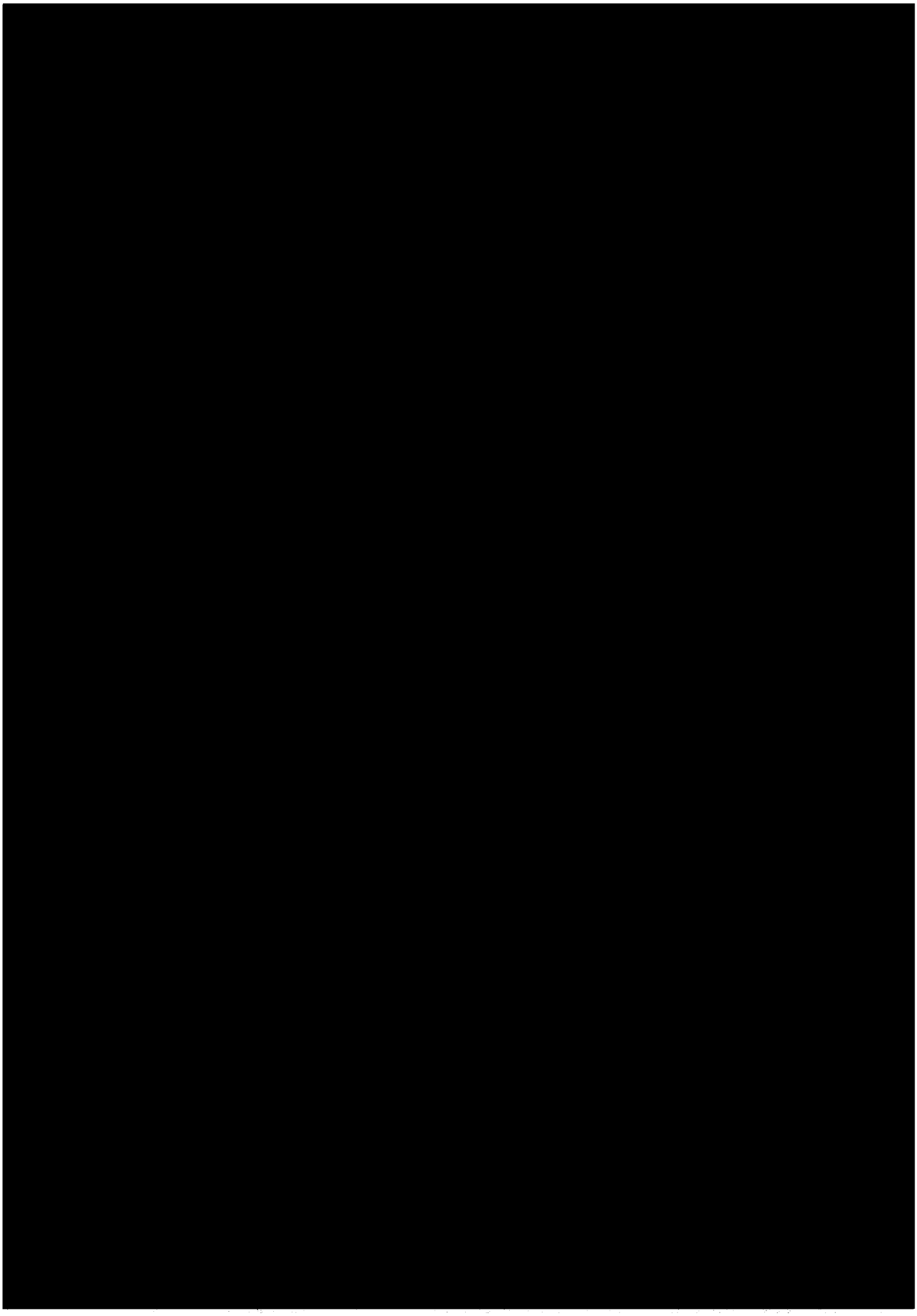
GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

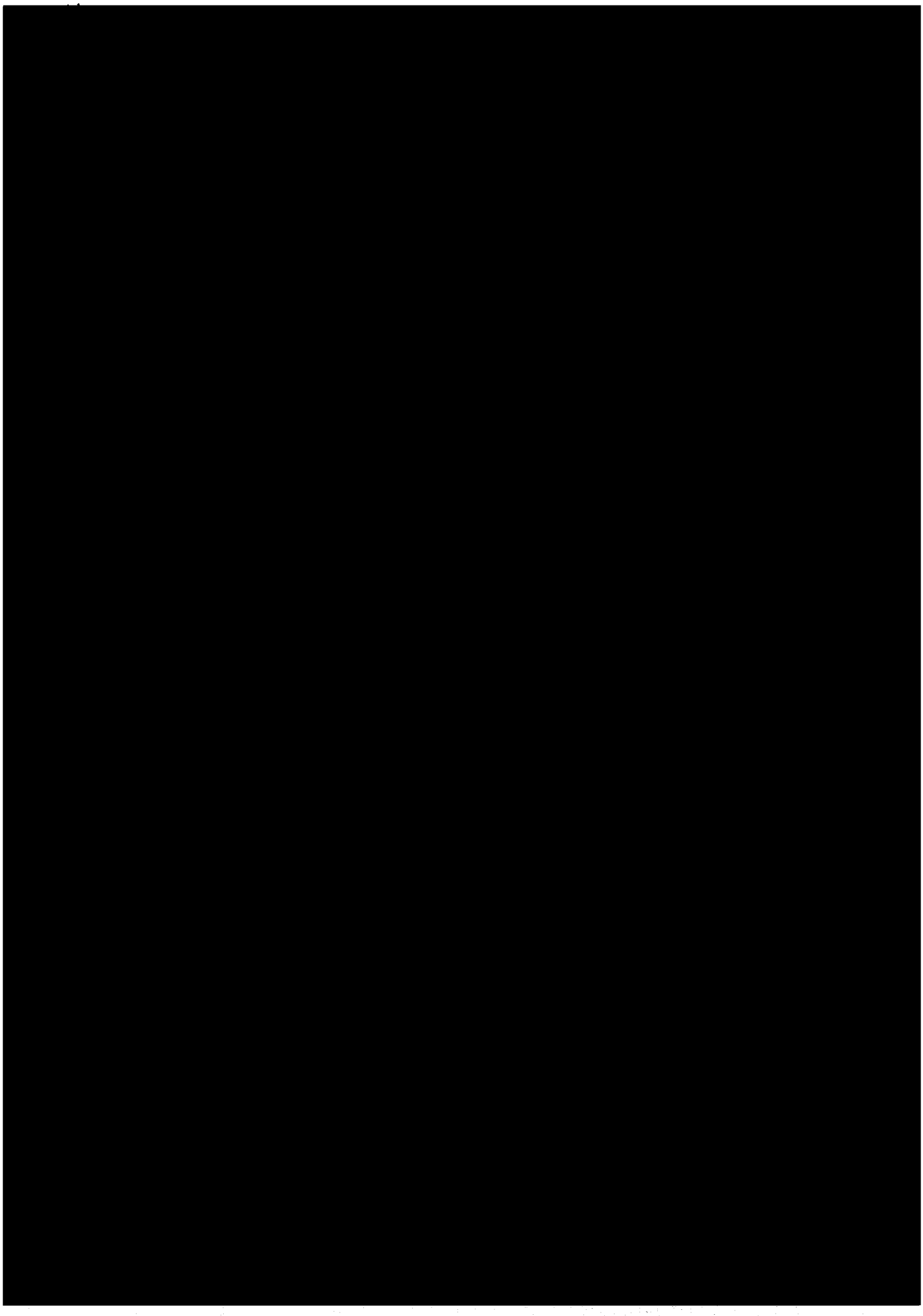
Further to our telephone conversation, please find attached the MDU's response on behalf of Dr Barton to the PPC item.

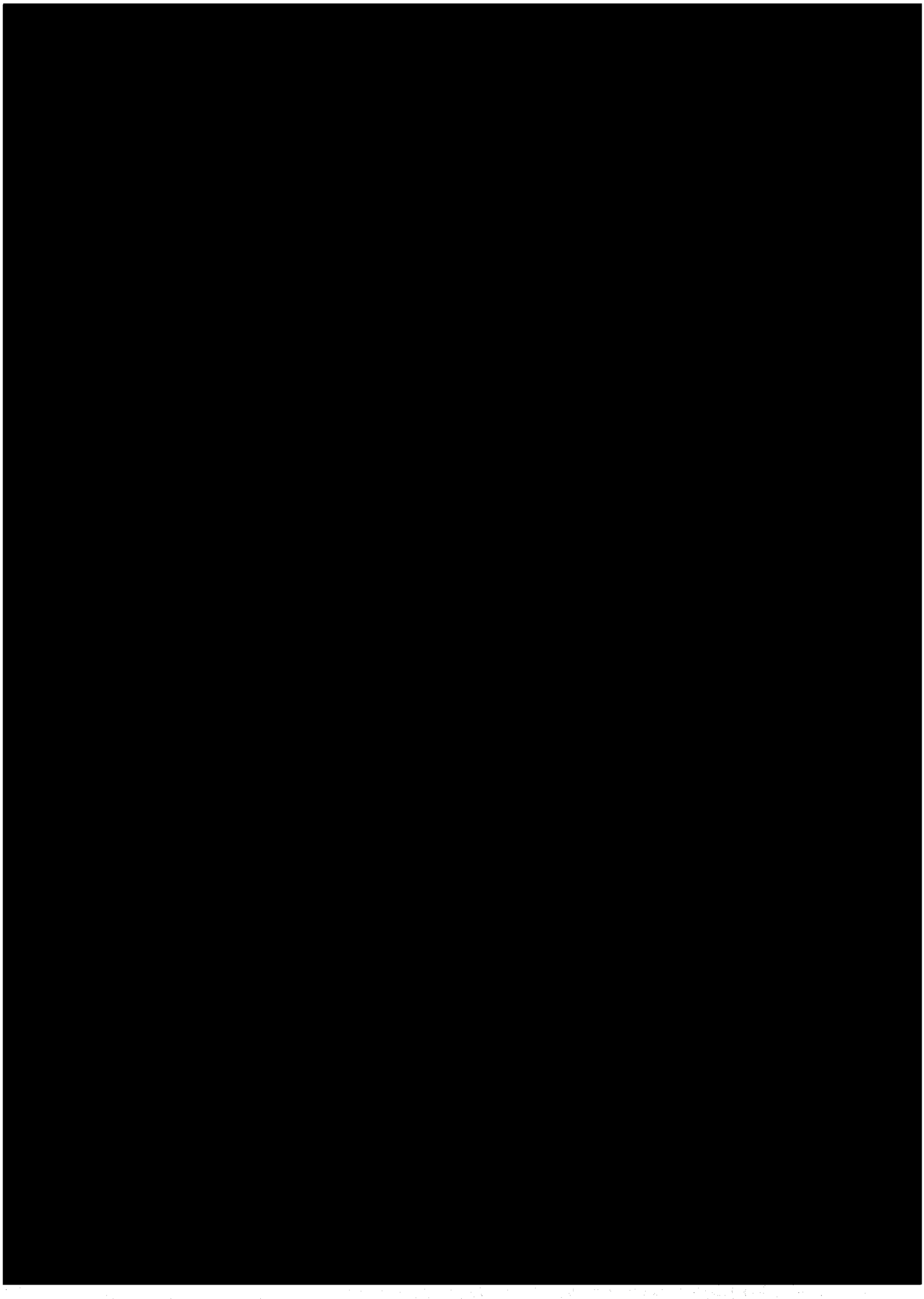
178 Great Portland Street London W1N 6JE

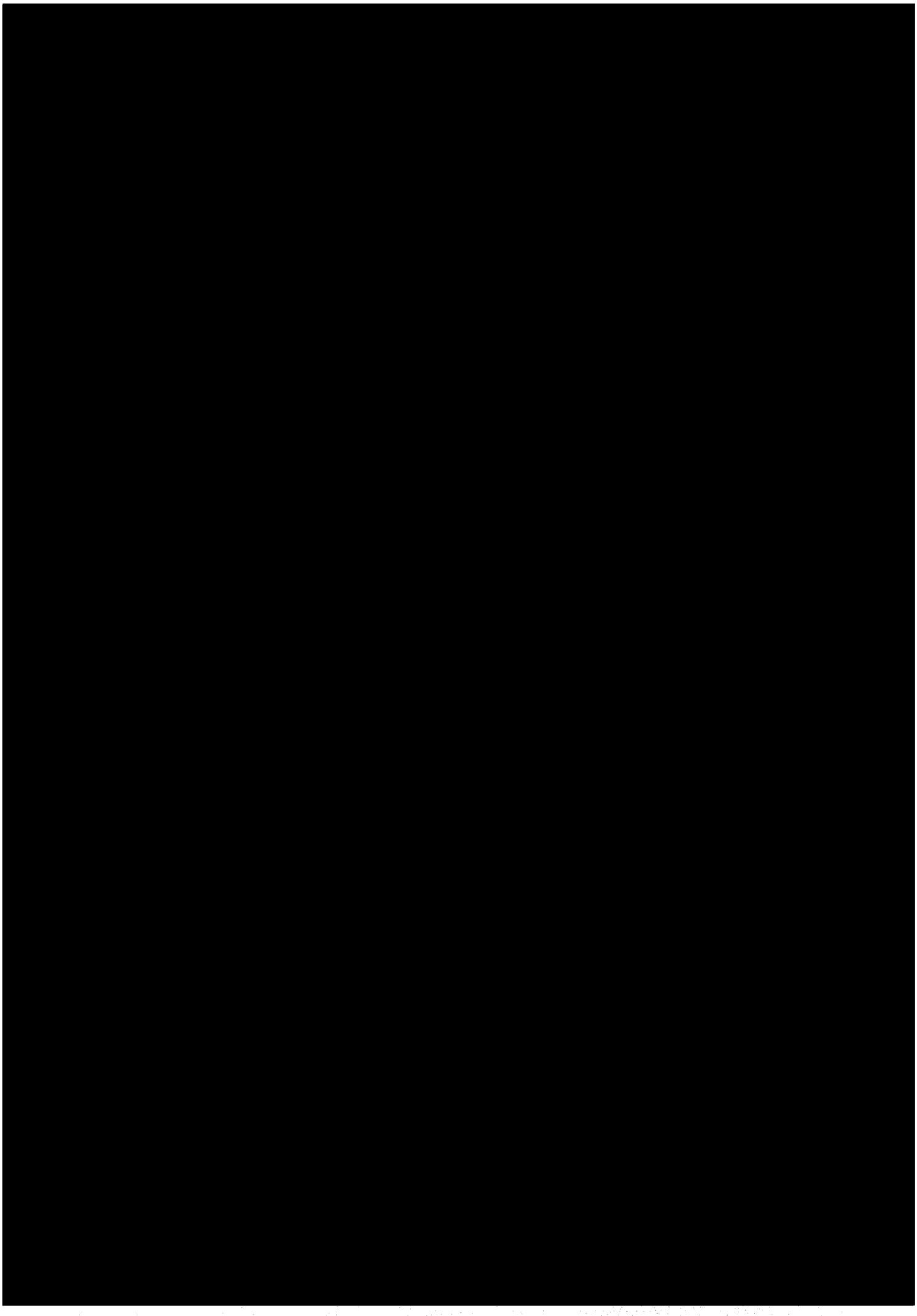


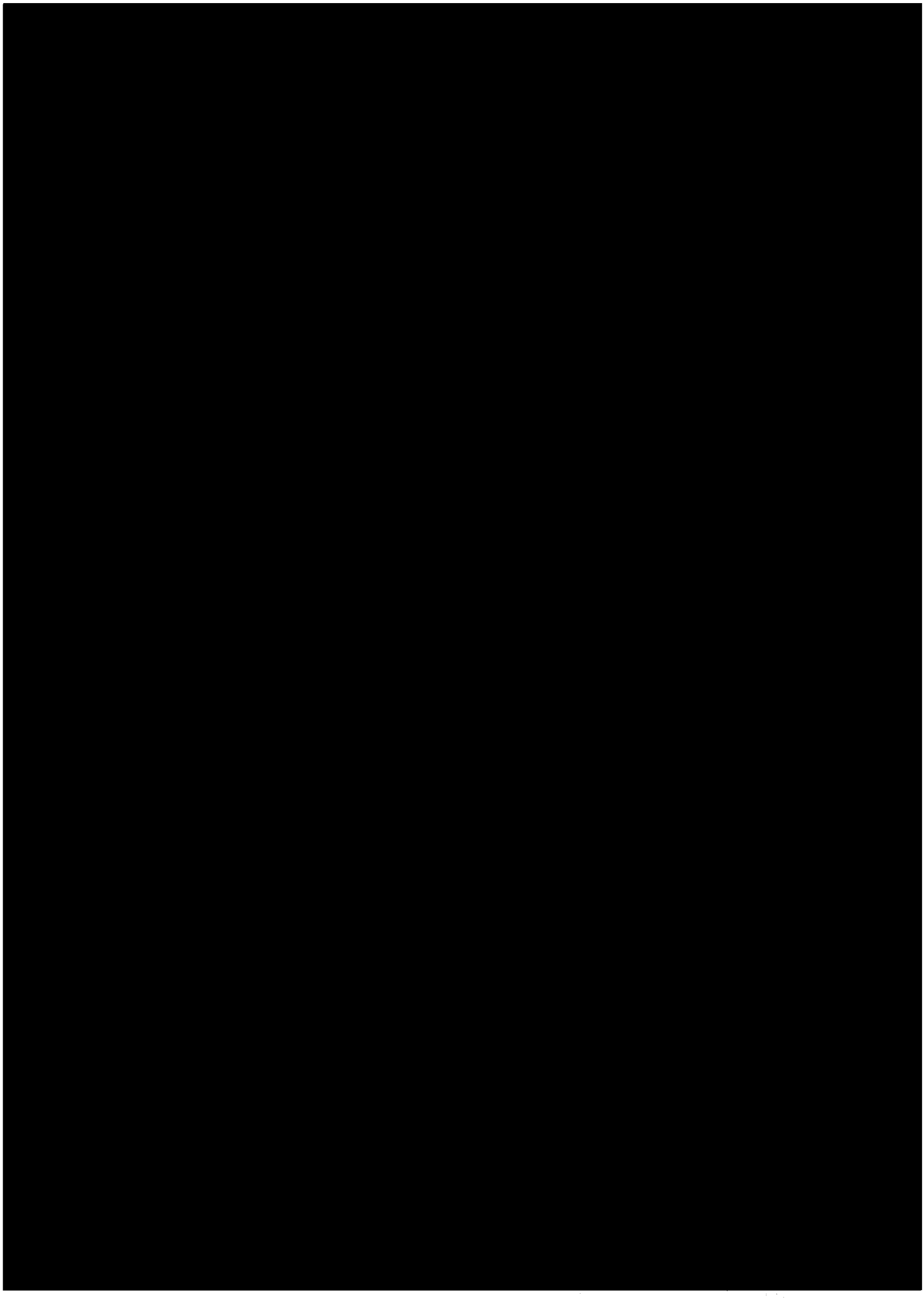


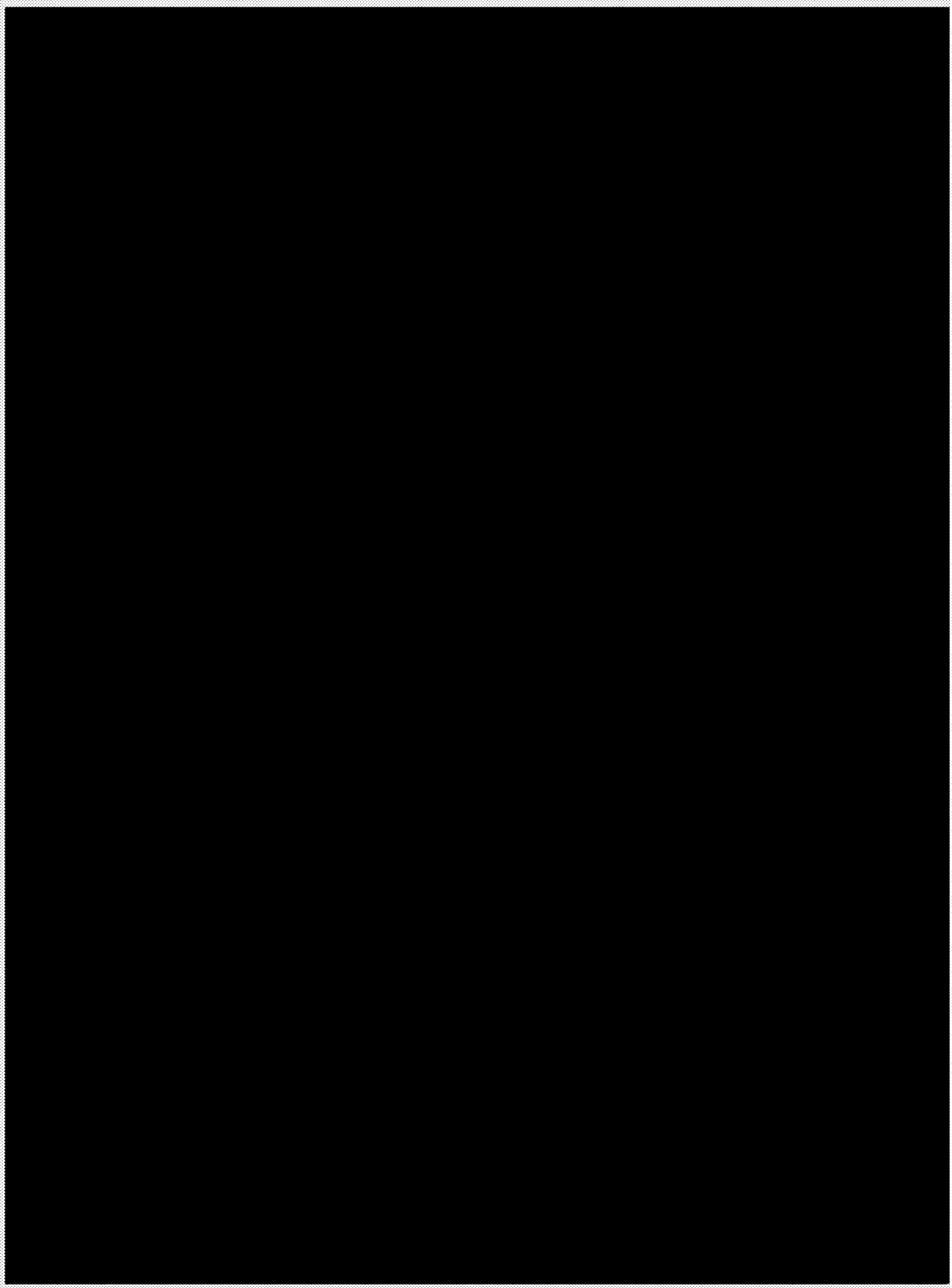












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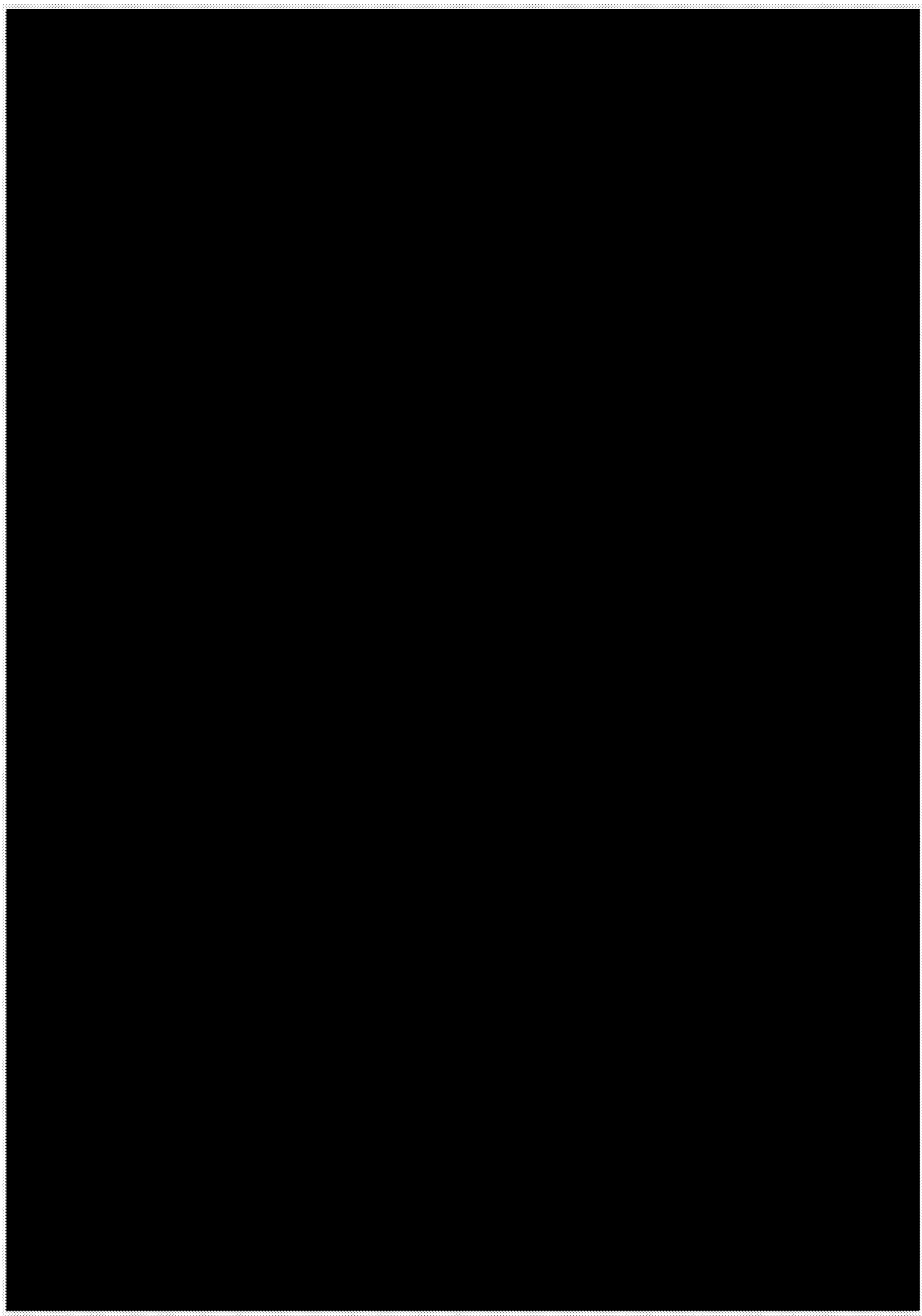
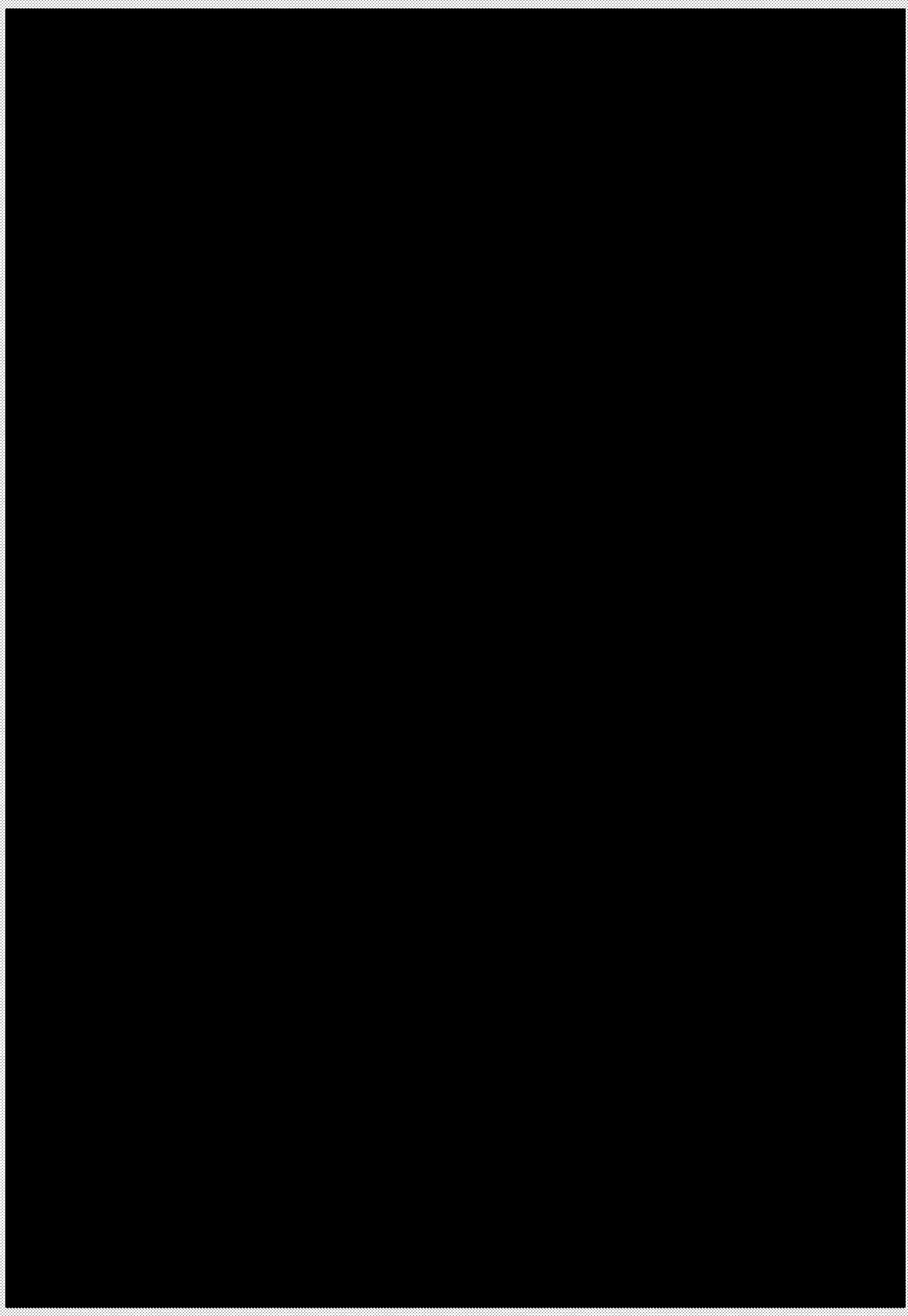
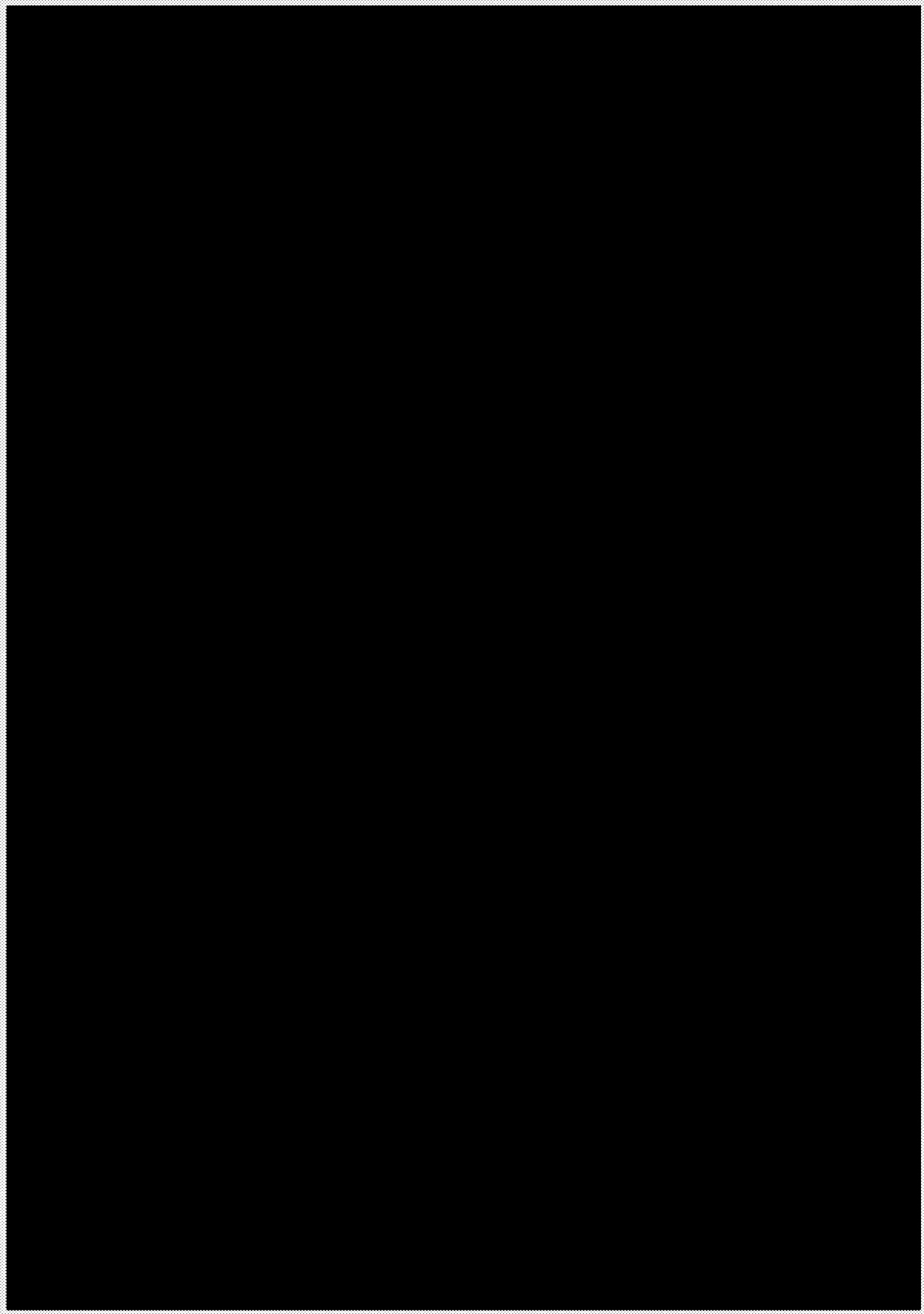
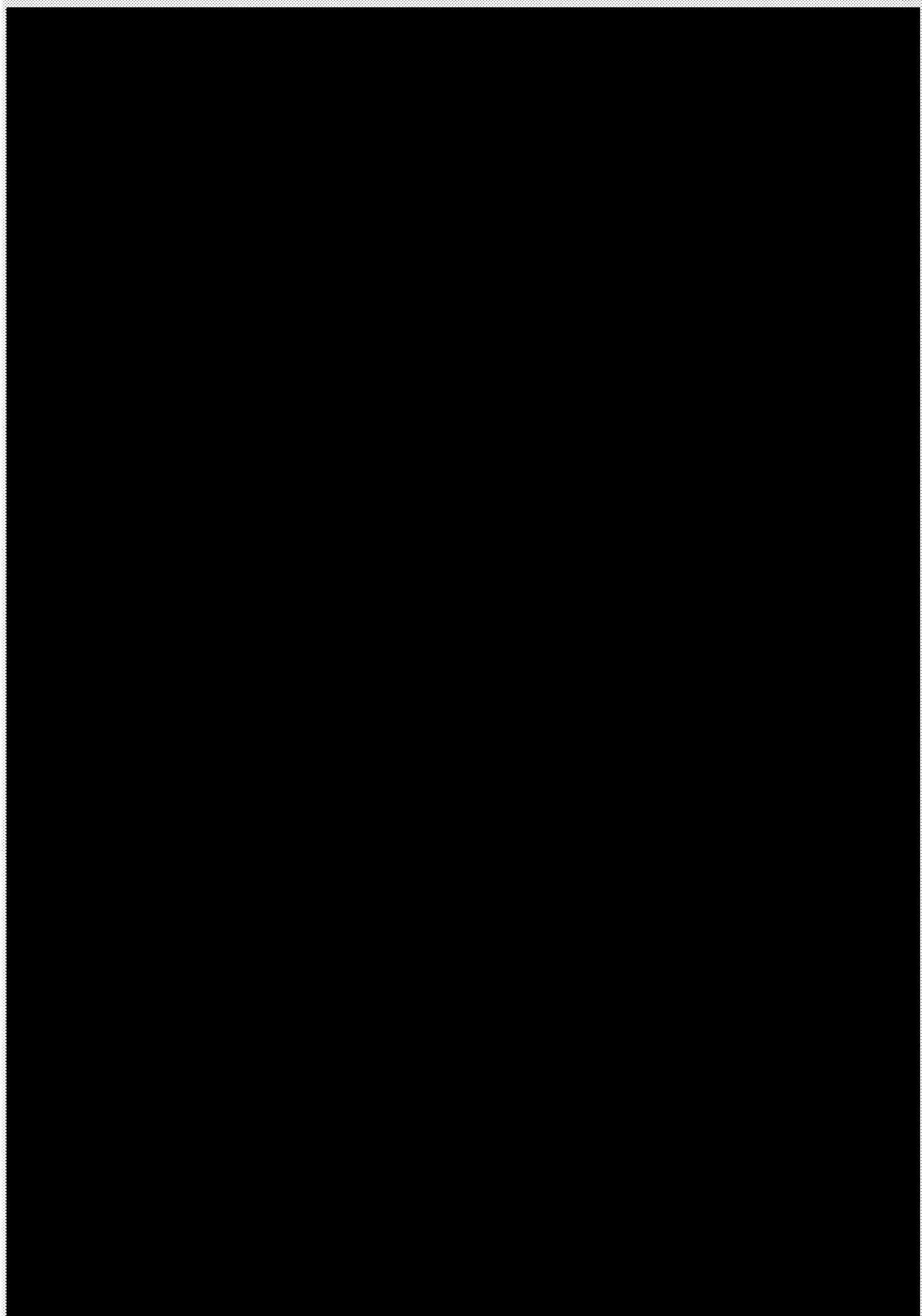








TRANSMISSION VERIFICATION REPORT

TIME : 18/09/2002 16:30
NAME : GMC
FAX : Code A
TEL :

DATE,TIME	18/09 16:28
FAX NO./NAME	Code A
DURATION	00:02:04
PAGE(S)	09
RESULT	OK
MODE	STANDARD ECM

Fax

To Mr I Barker

Fax number Code A

From Michael Keegan

Direct Dial Code A

Direct Fax

No. of pages (inclusive) 9 16:25 Date 18 September 2002

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Please see attached letter.

GENERAL MEDICAL COUNCIL
protecting patients, guiding doctors

Your reference: ISPB/TOC/0005940/Legal
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

18 September, 2002

Also by fax: 020 7202 1663

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

Dear Mr Barker

Thank you for your letter of even date.

I am able to clarify that I have no report from the Department of Health. I am sorry if this was not clear in my last letter. The telephone conversations have been with the Regional Director of Public Health (Mr Gill). I enclose telephone notes of conversations with both Mr Gill and the police.

I thank you for clarifying that the police have asked the CPS to express a view. I also wrote to the police asking for a summary of the current situation and they today confirmed that papers in addition to those first considered by the CPS were submitted this week and that they await a response from the CPS.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

TELEPHONE MESSAGE PAD

FROM .....

TO .....

TIME/DATE .....

GENERAL MEDICAL COUNCIL
Protecting patients guiding doctors

GG 1356

Rec'd a call from Inspector Mark Wise Hampshire police re Lester. Calling on behalf of Deputy Chief Constable who is meeting relatives of patients who died under her care this pm.

I confirmed a Stuck Conference Call to Barbara had been referred to PCC - stressed that Police not to front + relatives must not be told.

Case to be handled by Superintendent Paul Baker **Code A**.

Code A

1/9

Message taken by .....

Michael Keegan Code A

Sent: Paul Philip Code A
12 Sep 2002 12:28
To: Vanessa Carroll Code A Peter Swain Code A
Cc: Michael Keegan
Subject: RE: Inquiry re: Dr J Barton

Peter,

Can we discuss please.

Paul

-----Original Message-----
From: Vanessa Carroll Code A
Sent: 12 Sep 2002 10:07
To: Peter Swain Code A
Cc: Michael Keegan Code A Paul Philip Code A
Subject: RE: Inquiry re: Dr J Barton

I have now spoken with Mike Gill who informed me in confidence that the CMO has now looked at all the papers in this case having been notified by a whistleblower (not identified to me). The CMO wants a full investigation into the deaths in that hospital, the handling of which is going to be difficult and public as the whistleblower is likely to go to the press in a matter of days.

I informed Mike Gill that the police were again involved with this case and that Superintend. Paul Stickler was responsible for the case. Mike Gill indicated that he would contact the police.

MG is concerned that the ICC considered this case and made no order. I indicated that it was possible for ICC to reconsider if new information was placed before it. He will discuss this with the police. MG is concerned that when this becomes public, questions will be asked about Dr being allowed to continue to practise. MG used the expression "institutional euthanasia".

It was left that MG would speak to the police.

If the police are going to proceed or there is going to be an inquiry then this of course may affect any action the GMC takes.

Vanessa

-----Original Message-----
From: Peter Swain Code A
Sent: 12 Sep 2002 09:13
To: Scott Dickins Code A Paul Philip Code A Vanessa Carroll Code A
Cc: Michael Keegan Code A
Subject: RE: Inquiry re: Dr J Barton

Vanessa

This case was allocated to Michael under your mentorship. Please could you telephone Mike Gill this morning.

Peter

-----Original Message-----
From: Scott Dickins Code A
Sent: 12 Sep 2002 08:58
To: Paul Philip Code A Peter Swain Code A
Subject: Inquiry re: Dr J Barton
Importance: High

Mike Gill, Regional Director of Public Health, SE region, telephoned thismorning Code A to discuss a serious matter relating to the case of Dr J Barton, who was apparently referred by PPC to PCC end of last month.
MG asked if we could get back to him before 10:30 thismorning.

Scott

TELEPHONE MESSAGE PAD

FROM Vanessa Carroll

TO Re: BACTON

TIME/DATE 12/9/02

GENERAL MEDICAL COUNCIL
Protecting patients guiding doctors

Mike Gill - Regional Director Manic Depression Research Network telephoned re: Dr Barton to inform me that the police are now Examining 4 more cases to CPS Quantity previously only submitted one case Diagnosis Records - Police now considering 3 cases. I informed Mike Gill that GMC considering re-referral to IOC & would keep him informed. Explained provided in confidence.

Code A

12/9/02.

Message taken by

Mike Gill

Code A

copied to Friday 13/9/02 MS

Department of Health

Department of Health
Investigations and Inquiries Unit
Room S43B Skipton House
80 London Road, London SE1 6LH

Telephone: Code A
Mobile:
Fax:

email: Code A

From: Michael Evans

To: Paul Philip GMC

Fax no: Code A

Pages (including this): 2

Date: 13 September 2002

Message:

For information

Please see the attached press release issued by the Department of Health this afternoon.

2002/0380

Friday 13th September 2002

GOSPORT WAR MEMORIAL HOSPITAL

STATEMENT FROM THE CHIEF MEDICAL OFFICER SIR LIAM DONALDSON

Following the publication of the Commission for Health Improvement report and the police investigation into concerns about the care of elderly patients at Gosport War Memorial Hospital, the Chief Medical Officer has commissioned a clinical audit of the service concerned.

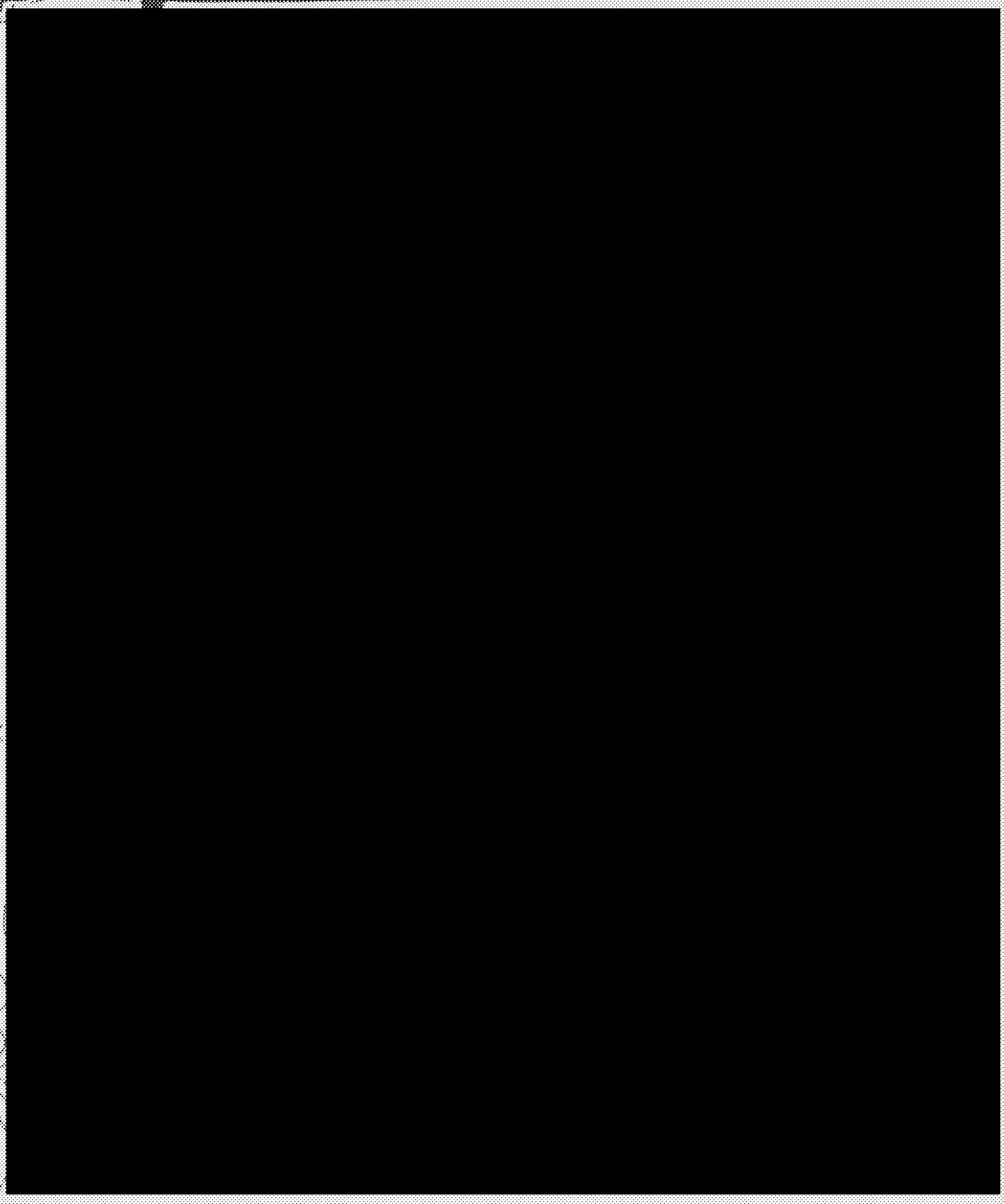
" Even though both previous investigations found no grounds for serious concern, neither was in a position to establish whether trends and patterns of death were out of line with what would be expected. It was a wish to ensure that all necessary investigation was carried out that led to the decision to carry out this further investigation.

" I have asked Professor Richard Baker from the Clinical Governance Research and Development Unit at the University of Leicester to undertake the audit. The timing of the audit will be agreed in consultation with the police," Sir Liam said.

Note to Editors:

1. Media inquiries only to Alison Pitts-Bland in the Department of Health Media Centre on Code A

[ENDS]



TELEPHONE MESSAGE PAD

FROM Rosie Ghera

TO Vanessa Carvalho

TIME/DATE 13/9/02 (16:12)

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Spoke to nurse Ali - informed her Dr Barton have been fed details of her telephone appearance letter to GOC on Thursday 19th Sept + referral letter. We send no colonoscopy after head first head surgery + doctor then she would be right enough to travel. Informed him that her legal representative been informed.

Code A

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref:
18 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 Michael Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: Code A

Dear Mr Keegan

Dr Jane Barton

Thank you for your letter of 17th September by fax. I am grateful also for the copy of the letter of 12th September to Dr Barton which accompanied your letter. I am sorry to say that any previous copy of the letter to Dr Barton has not yet arrived with me.

In your letter you state that I already have "a copy of the report considered by the PPC on 29th August 2002 and [you] can confirm that there has been no *further* written correspondence between the GMC and the Department of Health or, indeed, the Police" (emphasis mine).

This observation appears to suggest that there is in existence a report from the Department of Health, and indeed that this was available to the PPC. I have reviewed the papers provided to Dr Barton for the purposes of that hearing, and I am presently unable to locate any documentation at all emanating from the Department of Health. I would be grateful if you could clarify, and pass to me any such Department of Health material if it exists.

I note your observation that any additional information received has been received by telephone. Can I reiterate that I am concerned to have access to notes made of telephone conversations in this matter, including with the Police and Department of Health.

Can I also point out what appears to be a misunderstanding of the present position of the Police. You make reference to the fact that "the Police have apparently re-opened their investigations....". In fact, the Police have not done this. Following expression of concern by the relatives, the Police have referred the matter to the Crown Prosecution Service for the CPS to express a view. The Police have no new information or concerns in this matter. However, in circumstances in which it seems communications with the Police have been by way of telephone conversation, this underlines the importance of my request for notes of telephone conversations, including those with the Police, so the full extent of the picture can be seen clearly.

Our ref: ISPB/TOC/0005940/Legal
Your ref:
18 September 2002

I look forward to hearing from you.

Yours sincerely

Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Your reference: ISPB/TOC/0005940/Legal
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

8 October 2002

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

Dear Mr Barker

RE: DR JANE ANN BARTON

I write to confirm that the Professional Conduct Committee meeting to consider the case against Dr Barton has been provisionally listed for three weeks commencing 17 March 2002.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Your reference: ISPB/TOC/0005940/Legal
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

1 November 2002

Mr I Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London SE1 9PJ

Dear Mr Barker

Re: Dr J A Barton

I refer to previous correspondence about the listing of your client's case at the Professional Conduct Committee.

I write to confirm what I advised by telephone, namely that the provisional listing has been adjourned in accordance with your request, to commence on 7 April 2003 and is scheduled for 15 days.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

THE MDU

Facsimile

The Medical Defence Union Limited
Legal Department

To:	Mr Michael Keegan
Company:	GMC
Fax no:	Code A
From:	Ian Barker
Date sent:	18/09/02
Time sent:	
No. of sheets inclusive:	3
Re:	Barton

If you do not receive legible copies of all the pages please notify us immediately by telephone or fax.

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref:
18 September 2002

Mr Michael Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: 0207-915-3696

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

Dear Mr Keegan

Dr Jane Barton

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Our ref: ISPB/TOC/0005940/Legal
Your ref:
18 September 2002

I look forward to hearing from you.

Yours sincerely

Code A

THE MDU

Facsimile

The Medical Defence Union Limited
Legal Department

To:	Ms Lorna Johnston
Company:	General Medical Council
Fax no:	Code A
From:	Ian Barker
Date sent:	17 September 2002
Time sent:	
No. of sheets inclusive:	2
Re:	**Jane Barton**

If you do not receive legible copies of all the pages please notify us immediately by telephone or fax.

Please quote our reference when communicating with us about this matter

Our ref: ISPB/sls/9900079/Legal
Your ref: 2000/2047
17 September 2002

THE 1 MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Freephone: 0800
Telephone: 020 7202 1500
Fax: 020 7202 1663

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

Ms Lorna Johnston
General Medical Council
178 Great Portland Street
London
W1W 5JE

Also by fax: 0207-915-3696

Dear Madam

Re: Dr Jane Barton

Although I have not received a copy of the letter to Dr Barton following the recent consideration of her case by the Preliminary Proceedings Committee, I understand that the case has been referred on to the Professional Conduct Committee.

I would be grateful if you could therefore provide me with all documentation available to the Council, pursuant to Rule 21 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988.

In particular, I would be grateful for sight of any documents relating to communications between the Council and the Department of Health in this matter, whether in letter form or of notes of telephone communication.

I look forward to hearing from you as soon as possible.

Yours faithfully

Code A

Please quote our reference when communicating with us about this matter

Our ref: ISPB/sls/9900079/Legal
Your ref: 2000/2047
17 September 2002

THE 1
MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Freephone: 0800
Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: mdu@the-mdu.com
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Ms Lorna Johnston
General Medical Council
178 Great Portland Street
London
W1W 5JE

Also by fax: 0207-915-3696

Dear Madam

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In particular, I would be grateful for sight of any documents relating to communications between the Council and the Department of Health in this matter, whether in letter form or of notes of telephone communication.

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Yours faithfully

Code A

TRANSMISSION VERIFICATION REPORT

TIME : 17/09/2002 16:12
NAME : GMC
FAX : 020-7915-3696
TEL :

DATE,TIME	17/09 16:11
FAX NO./NAME	972021663
DURATION	00:01:05
PAGE(S)	04
RESULT	OK
MODE	STANDARD ECM

Fax

To Mr Ian Barker

Fax number Code A

From Michael Keegan

Direct Dial **Code A**

Direct fax

No. of pages (inclusive) 4 *16:10* *Date* 17 September, 2002

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please see attached letter.

Fax

To Mr Ian Barker

Fax number Code A

From Michael Keegan

Direct Dial Code A

Direct fax

No. of pages (inclusive) 4 16:10

Date 17 September, 2002

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Please see attached letter.

Your reference: ISPB/sls/9900079/Legal
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

17 September, 2002

Also by fax: 020 7202 1663

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

Dear Mr Barker

Thank you for your letter of even date regarding the referral by the Preliminary Procedures Committee (PPC) of Dr Barton to the Professional Conduct and Interim Orders Committees.

I copied to you my letter of 12 September 2002 addressed to Dr Barton in which the PPC's decision was related. I attach a copy for your convenience.

You already have a copy of the report considered by the PPC on 29 August 2002 and I can confirm that there has been no further written correspondence between the GMC and the Department of Health or, indeed, the Police. Any additional information received, including that the police have apparently reopened their investigations, has been received by telephone.

I am sorry that I can be of no further assistance at this time.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Under Seal - file

GENERAL MEDICAL COUNCIL

Protecting patients guiding doctors

12 May 2004

Sir Liam Donaldson
Chief Medical Officer
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Dear Liam

A review of deaths of patients at Gosport War Memorial Hospital

Thank you for your letter of 22 April 2004 regarding the above. I can confirm that it would be useful for the GMC to see a copy of Professor Baker's report, although, as you point out, without the authority to disclose this to Dr Barton, it will not be possible for the GMC to use this for evidential purposes. I would be happy to keep you up to speed with our progress on this matter. I would be grateful if you could mark Professor Baker's report for my special attention, to avoid any confusion at this end on receipt.

As stated at our meeting on 11 February, the GMC is in a difficult position vis a vis taking the matters relating to Dr Barton forward without access to any information which the police may have arising from their investigation. You will recall that the police are unwilling to confirm to the GMC that the nature of the information is significant from the perspective of the continued right of Dr Barton to practise. However, they have confirmed that, even if they did have such information, they would not share this with the GMC, as it would compromise their investigation and any possible subsequent prosecution that might take place.

Since our meeting on 11 February, I have met with senior investigating officers to attempt to find a solution to this problem, given the GMC's (and, indeed, your own) concerns in relation to Dr Barton. Although they confirmed that the investigation is on-going, little progress on the position stated above was made. Given this, we are instructing specialist counsel to advise on the respective positions of the police and the GMC to ascertain our position, should we choose to invoke Section 35A of the Medical Act 1983 and ask the court to use its powers to demand any relevant information from the police.

178 Great Portland Street, London W1W 5JE Telephone 020 7580 7642 Fax 020 7436 3644
email gaw@gmc-uk.org www.gmc-uk.org
Registered Charity No. CC00327

In the meantime, we have recently written to the police, setting out the position as we understand it and, once again, formally requesting disclosure in the interests of the protection of the public. I enclose a copy of our letter.

Please do feel free to contact me at any time on this matter.

Yours sincerely

Code A

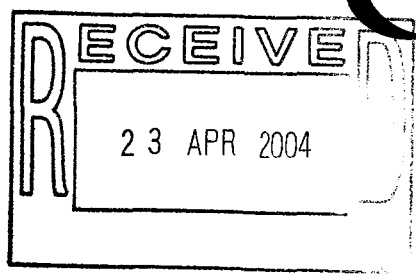
Paul Philip
Director of Fitness to Practise

Code A

2004-194

Linda Quinn
Paul Philip

From the Chief Medical Officer, Sir Liam Donaldson



DH Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: +44 (0)20 7210 5150-4
Fax: +44 (0)20 7210 5407

Code A

www.doh.gov.uk/cmo

22 April 2004

Personal and confidential
Mr Paul Philip
Director of Fitness to Practise
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Paul,

A Review of Deaths of Patients at Gosport War Memorial Hospital

Thank you for coming to our meeting on 11 February 2004 to discuss progress at the Gosport War Memorial Hospital and in particular Professor Baker's Report.

As you know, following allegations about the care and treatment of elderly patients at Gosport War Memorial Hospital, both the Police and the Commission for Health Improvement (CHI) have investigated allegations dating back to 1997. These focused on prescribing practices in a small number of wards in the hospital.

While initial investigations by the Police were inconclusive, investigations were reopened last year following further allegations about patient care. That investigation, into 62 deaths, is continuing and is unlikely to conclude before the summer of 2004.

In the meantime, on 5 September 2002, in the light of concerns raised by both the police and CHI, I commissioned Professor Richard Baker (who undertook the audit of Dr Shipman's patients) to carry out a review of patient deaths at Gosport Hospital. I received Professor Baker's final report towards the end 2003.

At our meeting, we discussed the status of that report and that we were constrained from publishing at this time because of the continuing police investigation. However, I do have concerns about some of the issues raised in the report, particularly in relation to Dr Jane Barton, which, following our meeting, I think you need to be aware of.

As you will appreciate, because Dr Barton has not seen the report nor has she had an opportunity to comment on any of its contents, we discussed the possibility of the report being used to provide you with background information about the history of events and allegations at Gosport War Memorial Hospital. I agreed that on that

Department of Health

basis to make a copy of the report available to you in confidence, provided that it is not disseminated or discussed more widely than is necessary. Clearly, in view of the Police investigation you would not be able to use the report for GMC evidential purposes at this time.

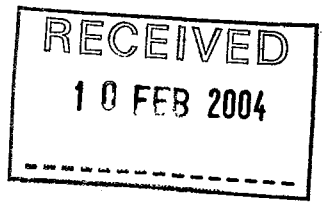
If you are content, I should be grateful if you would confirm this and I will send you a copy of the report in confidence.

Kind Regards

Code A

SIR LIAM DONALDSON
CHIEF MEDICAL OFFICER

Fareham and Gosport NHS
Primary Care Trust



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

Tel: 01329 233447
Fax: 01329 234984

Ms Linda Quinn
Senior Case Worker
General Medical Council
Fitness To Practice Directorate
178 Great Portland Street
LONDON
W1W 5JE

9 February 2004

Dear Ms Quinn

Further to my telephone conversation with you today, I can confirm that the practice in which Dr Jane Barton (a local GP in the Gosport area) is based is part of a 'bed fund'. This fund is designed to enable local GP practices to admit their patients for appropriate care, supervised by the GP, paid for by the PCT as a service.

Approximately, 18 months ago Dr Barton agreed voluntarily not to admit patients to the hospital nor supervise any patients in the hospital.

This is the current position and it has not changed over time.

As Dr Barton is a GP her relationship with the PCT is one of providing a service for which payment is made, consequently she is not an employee and the issue of suspension in any form does not apply in this case.

I trust this clarifies matters. Please contact myself or Ms Fiona Cameron, Director of Nursing and Clinical Governance should you require any further information.

Yours sincerely

Code A

Alan Pickering
Deputy Chief Executive

Code A

Don Aston,

Code A

Ms Linda Quinn,
General Medical Council,
178, Great Portland Street
W1N 6JE

10th January 2004

Dear Ms Quinn,

1587920 Dr Jane Ann Barton

Please excuse this note but you may remember kindly agreeing to speak to me regarding Dr Barton last Friday morning. My interest in her case arises because once again it concerns the levels of opioid (and sedative) use considered appropriate to relieve physical pain and mental distress in the later - and perhaps terminal - stages of life.

The attached sheet attempts to show the major disparities in the published sources of guidance available to doctors prescribing opioids in palliative care. The BMA for instance still simultaneously publishes two such incompatible sources - the six-monthly British National Formulary and the BMJs hospice-influenced ABC of palliative care. These of course would have been available to Dr Barton and her colleagues at the time they were prescribing for Gosport patients unlike the various ' expert ' witness opinions which have apparently since been obtained. The CHI investigation unfortunately refers only to the BNF and to the apparently far more restrictive local ' Wessex Guidelines ' (para 7.9). The BNF incidentally does justify anticipatory prescribing: ' Analgesics are more effective in preventing pain than in the relief of established pain ' quite apart from the more general point that Dr Barton was a full-time GP only able to make brief and perhaps infrequent visits. This of course was a situation similar to that in nursing homes where up to a quarter of all deaths of elderly people now take place and from a much wider range of illnesses/conditions than for example in a hospice with continuous medical cover.

On the basis of such information as has been made public needless to say I feel tremendous sympathy for Dr Barton. It is appreciated that you would no doubt find acknowledging or answering this letter extremely difficult but it is hoped that you at least have some sympathy with the points made in it.

even if few wanted to that is!

With very best wishes

Code A

SOURCES OF GUIDANCE AVAILABLE TO DOCTORS ON THE USE OF OPIOIDS IN TERMINAL CARE

Incompatibilities between sources relate to:

- Indicative dose ranges (please see below)
- Proportion of patients said to be likely to require high doses (please see below)
- Acceptable rate of dose increase when required
- Treatment of opioid toxicity

Ambiguities relate to:

- Assumed administration route ie oral or parenteral
- (in some sources) Particular opioid to which the indicative dose range relates

ooOOoo

Source	Indicative Dose Range (Assumed to be Oral Morphine Equivalent per 24 hours)
British National Formulary no 32 (to March 97)	30 to 900mg
British National Formulary no 33 (from March 97)	30 to 3, 000mg
MIMS	No upper limit " Contrary to popular misconception, there is no maximum dose for morphine in [severe pain] "
Typical Hospice (eg Palliative Care Handbook Open University K260)	15 to 15, 000mg (assumed smooth progression over dose range)
British Medical Journal Sept 97 (ABC of palliative care)	30 to 15, 000mg (" very few need high doses – most require less than 200mg a day ")
Palliative Care Formulary 1 Twycross etc	One-third of patients need in excess of 200mg and up to 1, 200mg
Oxford Textbook of Palliative Medicine	15 to 15, 000mg (" whilst most patients require 200mg/day or less some need much higher doses ")
Oxford Textbook of Oncology Vol 2	30 – 40% of patients will require more than 200mg

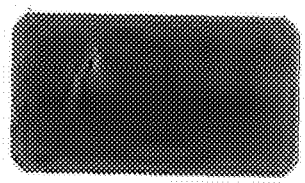
(continues)

Cancer Pain Management –
McGuire etc &
Textbook of Pain 3rd Ed
Wall & Melzack

400 – 600mg average
Requirement – 10%
Require more than 2, 000mg
Intramuscularly citing Coyle et al
(1990) Journal of Pain Management

Hospice Palliative Consultants on Opioid Overdoses

" Even with accidental overdose 5 – 10 times the routine dose, the patient is only likely to become drowsy for a few hours and then recover spontaneously. " Dr Kilian Dunphy " There is abundant evidence of people having been given inadvertently 20, 30 and even on one occasion 100 times what had been prescribed. Whilst it can be a tragic error, the patient may wake up 4 hours later to say it is the best sleep he has had for some time ..... there is no danger in these drugs. " Dr Derek Doyle



Your reference:
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
protecting patients guiding doctors

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

4 October 2002

Ms J Miller
Commission for Health Improvement
103 – 105 Bunhill Row
London EC1Y 8TG

Dear Ms Miller

Re: Dr J A Barton

As you already know, the Council's Preliminary Proceedings Committee recently referred the case of Dr Barton for inquiry by the Professional Conduct Committee and we are now preparing for that.

I already have a copy of the CHI report on the Gosport War Memorial Hospital dated July 2002. When we last spoke you indicated that you would be prepared to make available the background documentation gathered and prepared by yourselves and I should now be grateful if you would copy the same to me as soon as possible.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

copied to finlay 13/9/02 MB

COPY

Department of Health

Department of Health
Investigations and Inquiries Unit
Room 543B Skipton House
80 London Road, London SE1 6LH

Telephone:
Mobile:
Fax:

Code A

email: Code A

From: Michael Evans

To: Paul Philips GMC

Fax no: Code A

Pages (including this): 2

Date: 13 September 2002

Message:

For information

Please see the attached press release issued by the Department of Health this afternoon.

Code A

2002/0380

Friday 13th September 2002

GOSPORT WAR MEMORIAL HOSPITAL

STATEMENT FROM THE CHIEF MEDICAL OFFICER SIR LIAM DONALDSON

Following the publication of the Commission for Health Improvement report and the police investigation into concerns about the care of elderly patients at Gosport War Memorial Hospital, the Chief Medical Officer has commissioned a clinical audit of the service concerned.

" Even though both previous investigations found no grounds for serious concern, neither was in a position to establish whether trends and patterns of death were out of line with what would be expected. It was a wish to ensure that all necessary investigation was carried out that led to the decision to carry out this further investigation.

" I have asked Professor Richard Baker from the Clinical Governance Research and Development Unit at the University of Leicester to undertake the audit. The timing of the audit will be agreed in consultation with the police," Sir Liam said.

Note to Editors:

1. Media inquiries only to Alison Pitts-Bland in the Department of Health Media Centre on Code A

[ENDS]

2002/0380 **Friday 13th September 2002**

GOSPORT WAR MEMORIAL HOSPITAL

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" I have asked Professor Richard Baker from the Clinical Governance Research and Development Unit at the University of Leicester to undertake the audit. The timing of the audit will be agreed in consultation with the police," Sir Liam said.

Note to Editors:

1. Media inquiries only to Alison Pitts-Bland in the Department of Health Media Centre on Code A

[ENDS]

Notification of Receipt of Contact

CHI
COMMISSION FOR H... IMPROVEMENT

Date: 18 September

Your Ref: (037) MK/2000/2047

Dear Mr Keegan

Thank you for your letter/email/telephone call of 16 September 2002 received at the Commission for Health Improvement on 17 September. If appropriate, you will receive a response within 20 working days.

Yours sincerely

Code A

Investigations Department
11th Floor

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.

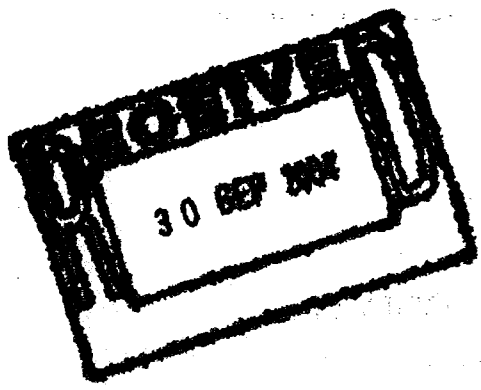
I have no other employment or contract either NHS or non NHS and I am not approved under Section 12 of the Mental Health Act.

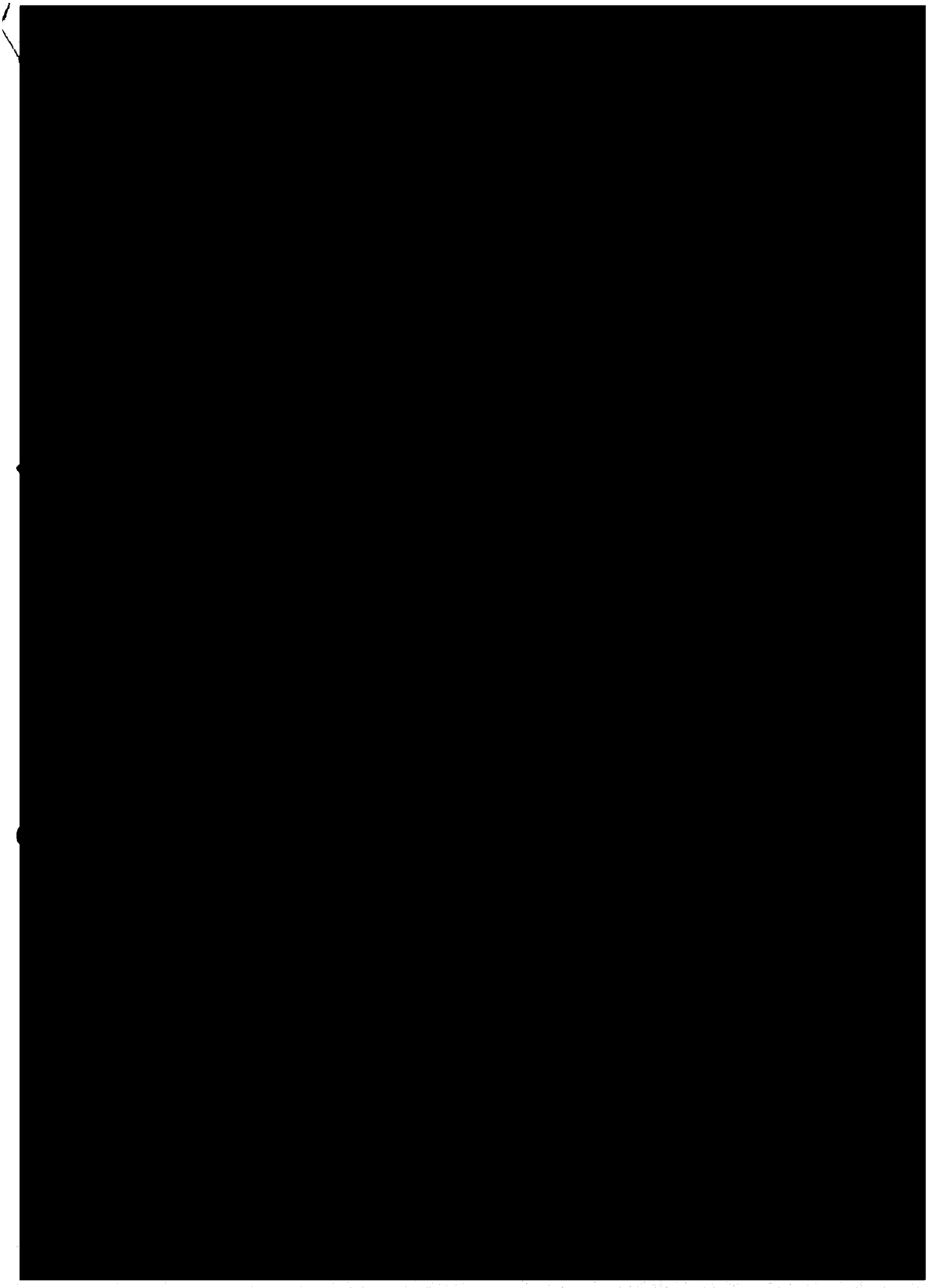
I propose to attend the hearing on 7th October 2004. I will be represented by my solicitor Ian Barker of the MDU .

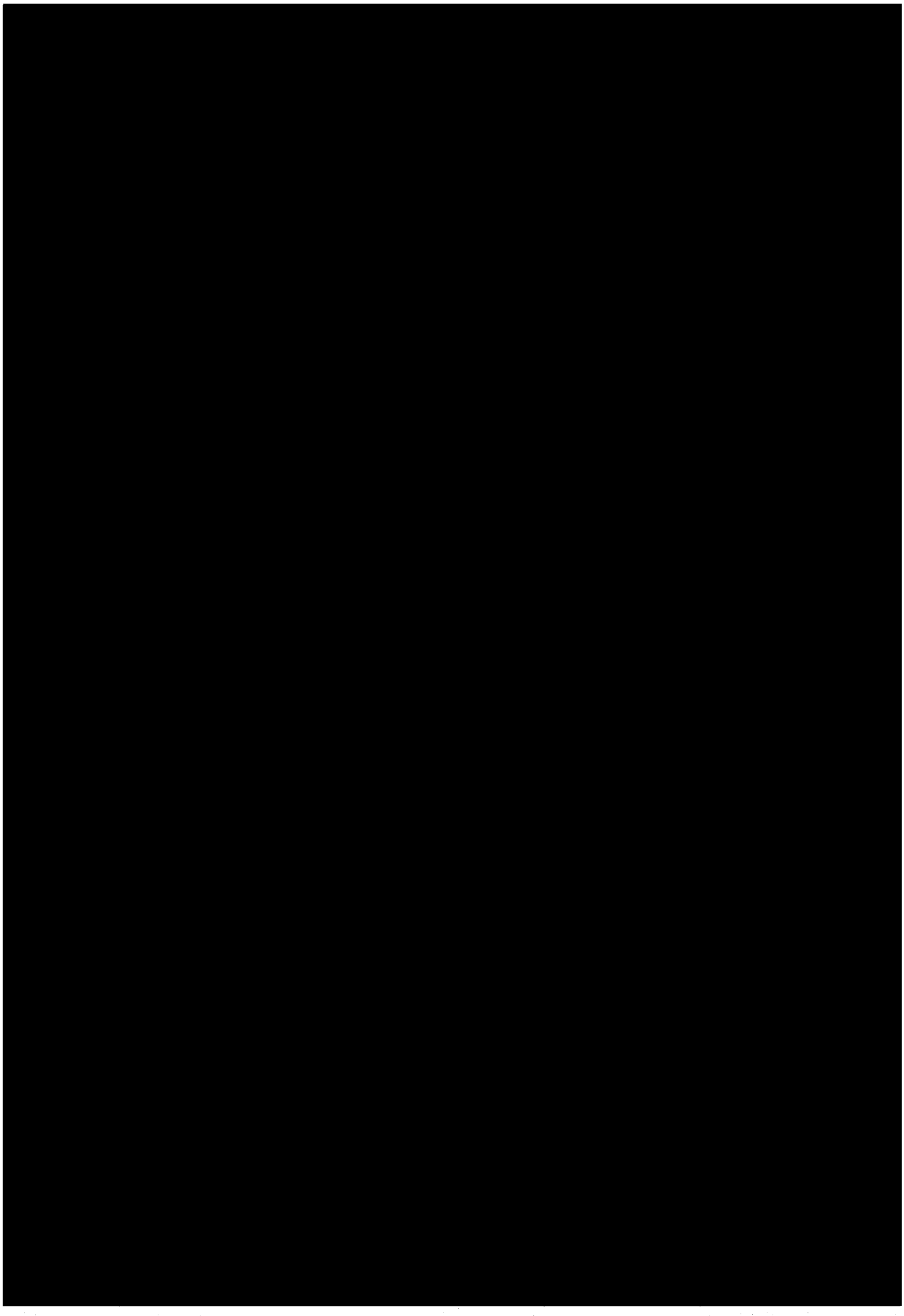
Yours Sincerely

Code A

Dr Jane Barton







[redacted]

Michael Keegan Code A

From: Peter Swain Code A
Sent: 10 Oct 2002 09:01
To: Michael Keegan Code A
Subject: RE: Dr Barton

Michael

I agree. We do not usually permit changes for non-availability of counsel; but this far in advance when we can't be sure of our own timetable it would seem churlish to 'die in the ditch' over what were in any event entirely guesswork dates. However, once we are firmer on our ideas about timetable, we will want to stick to the dates then agreed.

Peter

-----Original Message-----
From: Michael Keegan Code A
Sent: 09 Oct 2002 10:55
To: Peter Swain Code A
Subject: Dr Barton

Peter,

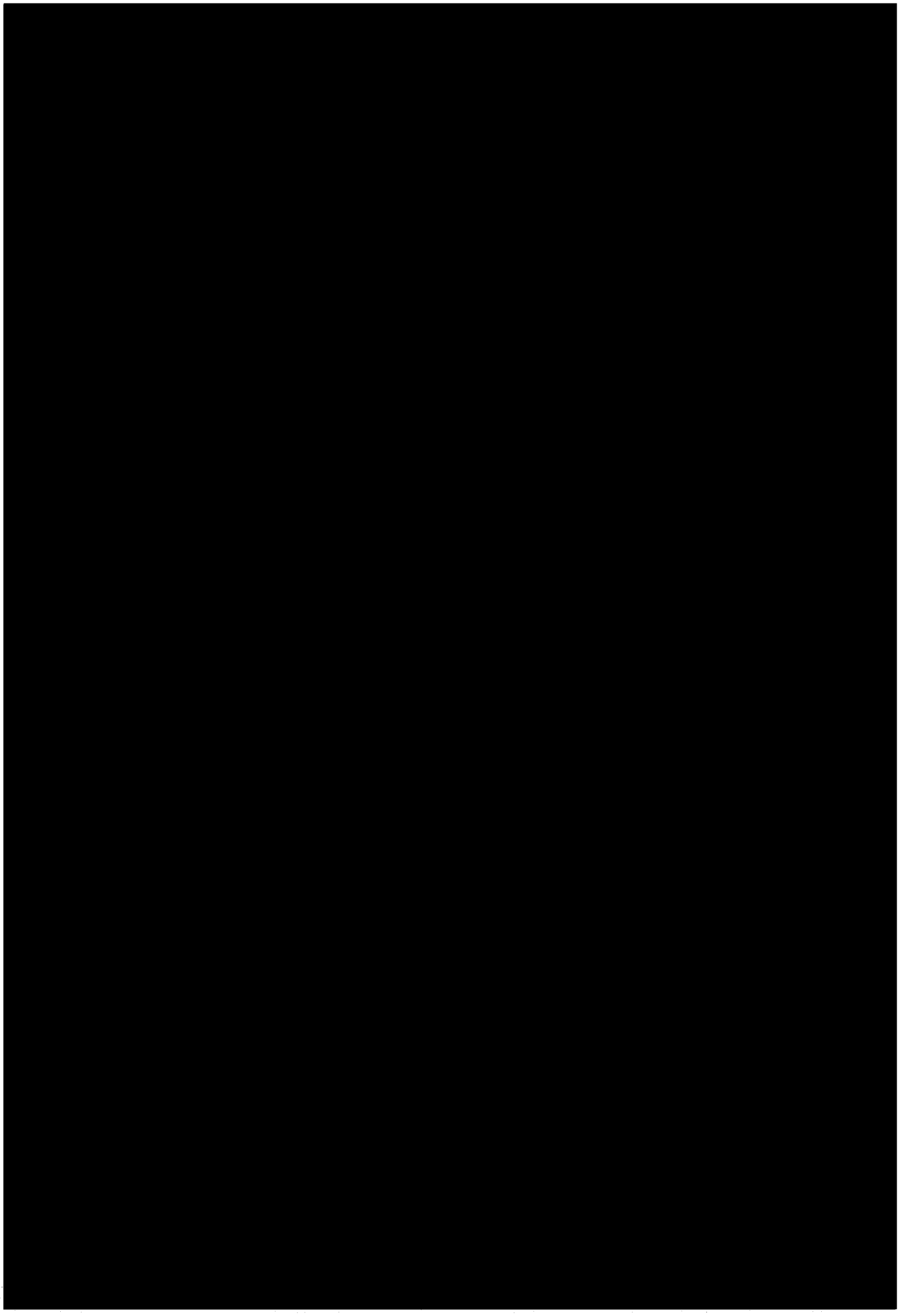
Ian Barker from MDU representing Dr Barton called re: provisional listing date (3 weeks from mid March). He says that these are the only weeks that counsel instructed at each of the 3 IOC hearings cannot make. He enquired whether there was any chance of relisting it, e.g. for 7 April onwards.

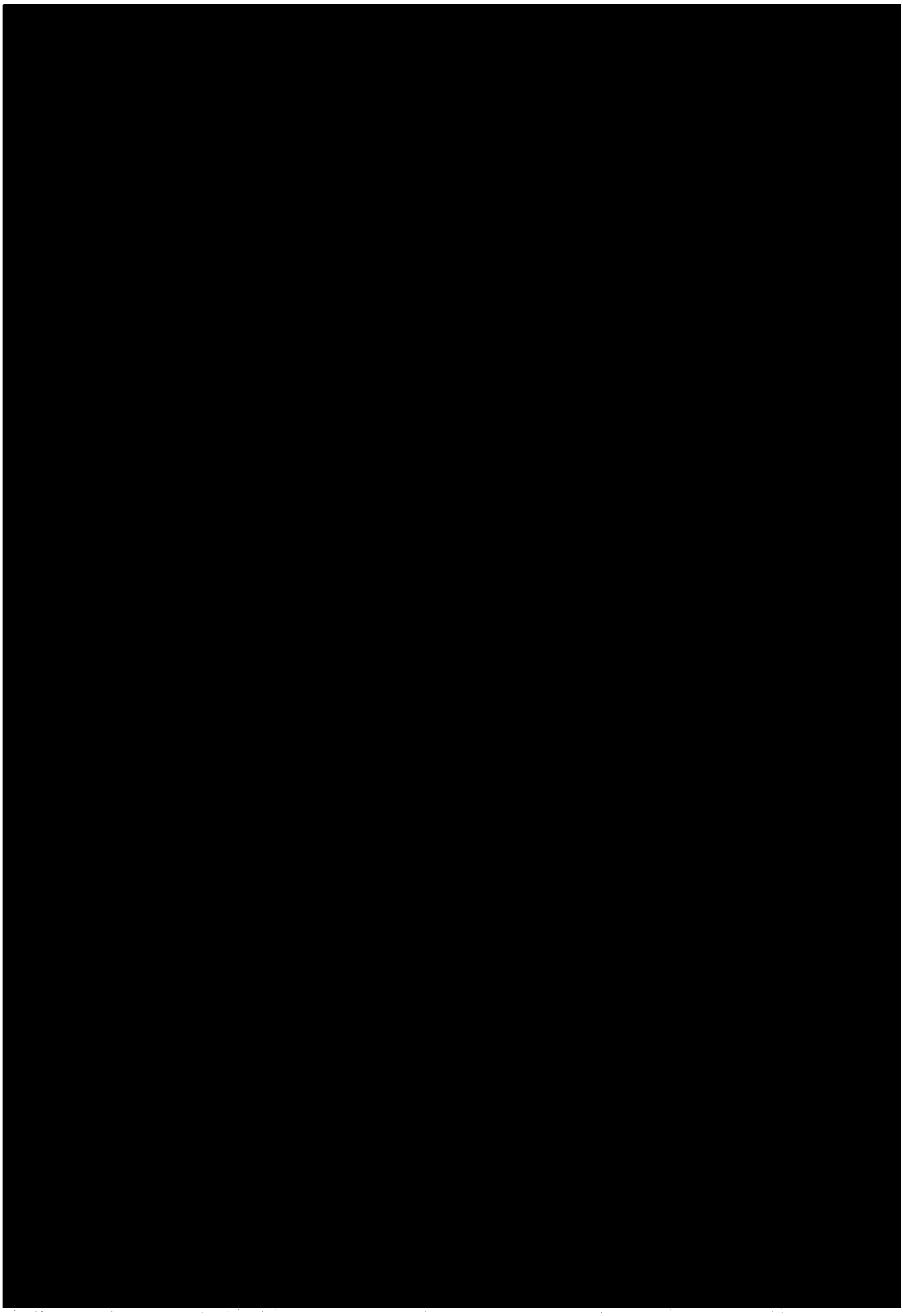
I know that we are keen to progress this case, but as it was a very provisional listing date I cannot see any real harm in agreeing to the slight postponement in the circumstances, but would welcome your comments before agreeing to anything.

Thanks

Michael

Michael Keegan
Conduct Case Presentation Section
Code A





Michael Keegan Code A

From: Peter Swain Code A
Sent: 27 Sep 2002 14:06
To: Venessa Carroll Code A Michael Keegan Code A
Subject: RE: Dr Barton

Venessa/Michael

Please could one of you ask Matthew Lohn at FFW for his written advice on whether there is anything in the material received since the last IOC, or any other new factor not previously known when the IOC considered the case, which would justify us in going back to the IOC once more.

I think we can guess what the probable answer will be, but it will be helpful to be able to tell the local authorities that our actions and decisons in respect of the IOC are based on formal legal advice.

Peter

-----Original Message-----
From: Venessa Carroll Code A
Sent: 25 Sep 2002 12:42
To: Peter Swain Code A Paul Philip Code A
Cc: Michael Keegan Code A
Subject: RE: Dr Barton

Paul and Peter

Further to the HA sending the dossier, Nigel McFetridge (head of Clinical Governance at the HA) has this morning called asking when the case will be reconsidered by the IOC. I understand that Mike Gill would also like this case to be referred back to IOC. Before taking steps to refer this back to IOC, I should be grateful for your views as to whether this is appropriate. To assist you, I have prepared the attached memo which summarises the new information. If you would like to see the new information, please let me know.

Thank you
Venessa

<< File: memoPhillips 02 09 25.doc >>

-----Original Message-----
From: Michael Keegan Code A
Sent: 23 Sep 2002 14:23
To: Venessa Carroll Code A
Subject: FW: Dr Barton

-----Original Message-----
From: Michael Keegan Code A
Sent: 23 Sep 2002 14:01
To: Paul Philip Code A Peter Swain Code A
Subject: Dr Barton

We have now received from Dr Simon Tanner, Director of Public Health at Hampshire and Isle of White Health Authority, a small file of correspondence, which was passed to the management of Fareham and Gosport Primary Care Trust by a member of staff on 16/9/02.

It includes copies of correspondence from the RCN Branch Convenor to various persons at the Trust and minutes and memoranda regarding meetings held with nursing staff to discuss their concerns about use of diamorphine in the unit.

I will provide copies of the same if you wish.

Michael.

Michael Keegan Code A

From: Venessa Carroll Code A
Sent: 25 Sep 2002 12:42
To: Peter Swain Code A Paul Philip Code A
Cc: Michael Keegan Code A
Subject: RE: Dr Barton

Paul and Peter

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Venessa

memoPhillips 02 09 25.doc

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I will provide copies of the same if you wish.

Michael.

Memorandum

To **Paul Philip**
Peter Swain

From **Venessa Carroll**
Conduct Case
Presentation Section

Code A

Date **26/09/02**

Copy **Michael Keegen**

Dr Barton

1. In a letter of 19 September 2002, Hampshire and Isle of Wight Health Authority have provided a file of correspondence passed by nurses to the management of Fareham and Gosport Primary Care Trust.

2. I have listed and summarised the relevant documents contained in the file below. I have not referred to documents that I do not consider relevant.

3. The information relates to concerns that were raised in 1991 by nursing staff about the use of diamorphine. Although Dr Barton is not personally criticised, she was, with other doctors (Dr Logan), prescribing the diamorphine.

4. It would seem from the information that the nurses were extremely concerned and contacted both the RCN (Royal College fo Nursing) and Mrs Evans, the Patient Care Manager. The RCN was clearly concerned and questioned the actions of the hospital in dealing with this. It seems that by the end of 1991, the staff were satisfied that the matter had been considered and was resolved.

5. In considering whether this case should be referred back to IOC, one could consider that despite concerns being raised in 1991, Dr Barton did not address these as shown by the allegations in current case (1998). This suggests possible lack of insight and the possibility that this inappropriate practice continued from 1991 to 1998. However we have no information to support this and we have no information about Dr Barton's practice since 1998.

Information provided in File

6. **Summary of Meeting on 11 July 1991 following concerns expressed by some staff at the prescribed treatment for terminal patients.**

This was a meeting arranged for staff on unit and attended by nurses and patient care manager, Mrs Evans. Dr Barton does not appear to have attended. The main concern was use of diamorphine on patients, with the nurses concerned about it being used inappropriately. Reference is made to not all patients given diamorphine having pain, no other forms of analgesia being considered, patients deaths hastened. Mrs Evans told the nurses that Dr Barton and another Dr, Dr Logan would consider the nurse's views so long as they were based on proven

facts. Although Dr Barton is not specifically criticised, the suggestion is that the nurses were complaining about her, and possibly Dr Logan. It was agreed that more information would be obtained about diamorphine

7. **31 October 1991 - Report of a visit to unit by community tutor in continuing education, Ms Whitney.**

Purpose of visit was to discuss administration of drugs following a request for information from nurses. In attendance were a number of nurses (not Dr Barton). During this meeting the nurses identified particular cases of concern (e.g. pt prescribed diamorphine via syringe driver, when not in pain) and indicated concern that diamorpine being prescribed indiscriminately. It is noted that there are a number of cases causing nurses concern but too many to mention. Again Dr Barton is not named.

8. **4 November 1991 - Letter from community tutor enclosing copy of her report dated 31 October 1991**

Also sent to General Manager and Patient Care Manager at Gosport Hospital, as well as Principal at Solent School of Health Medicine and staff nurse at the meeting.

9. **Memo from Mrs Evans dated 7 November 1991 to all staff at unit incl Dr Logan and Dr Barton.**

Indicates that there is still concern about prescribing of diamorphine, which she has discussed with Dr Barton. Nurses asked to provide names of patients that they have concerns about so cases could be reviewed.

This memo was copied to Steve Barnes, RCN Officer.

10. **Letter to Mrs Evans from Steve Barnes dated 22 November 2001**

SB indicates that RCN office had been aware of concerns from early/mid 1991 and RCN had understood that concerns would be addressed and clear guidance/policy would follow as a result of very serious concerns. He is clearly concerned that actions have not been take to address concerns and states that they expect a clear policy to be agreed as a matter of urgency.

11. **2 December 1991, letter from RCN to Nurse Tubbritt confirming that they have the support of the RCN**

12. **Letter dated 2 December 1991 to St Mary's Hospital, Portsmouth, asking for advice on dealing with this matter**

13. **Letter from RCN to Nurse Tubbritt dated 10 December 1991** indicating that unless it is confirmed that a policy will be drawn up, then grievance procedures will be started

26 September 2002

14. **Notes of a meeting held on 17 December 1991** attended by nurses, Mrs Evans and Dr Barton. Purpose of meeting to discuss concerns about use of diamorphine. At the conclusion of this meeting it was agreed that if nurses had concerns about particular cases they could approach Dr Barton or the Sister for an explanation. Staff were asked if they felt there was a need for policy relating to nursing practice and it was agreed that it was not necessary. Mrs Evans stated that she was concerned about the way in which these matters were raised, making people defensive. Agreed that a further meeting would be arranged to ensure problems had been resolved.

15. **11 January 1992 letter from RCN concerned that problems still there.**

Michael Keegan Code A

From: Paul Philip Code A
Sent: 24 Sep 2002 17:38
To: Peter Swain Code A Michael Keegan Code A
Subject: RE: Dr Barton

Peter,

Thanks. I suggest we go ahead as you describe. Does someone need to tell whoever gave us the papers what is happening?

Paul

-----Original Message-----
From: Peter Swain Code A
Sent: 24 Sep 2002 17:10
To: Paul Philip Code A Michael Keegan Code A
Subject: RE: Dr Barton

These papers are from 1991 and demonstrate that nursing staff raised their concerns at that time about the extent to which diamorphine was used routinely and in considerable quantity for pain relief for terminally ill patients. It is said that some terminally ill patients died as a consequence of that prescribing - though when pressed the nursing staff seemed reluctant to name individual cases. The nursing staff were supported by the RCN representative and there followed some local meetings; but the outcome appears to have been an acceptance that ultimately prescribing is for the clinical judgement of the relevant doctor.

These papers are supporting evidence for the substantive PCC case and as such they should be passed to our lawyers; but they do not provide sufficient grounds for us to invite the IOC to reconsider the case.

Peter

-----Original Message-----
From: Paul Philip Code A
Sent: 24 Sep 2002 15:46
To: Michael Keegan Code A Peter Swain Code A
Subject: RE: Dr Barton

Peter,

Can you have a look at these please.

Paul

-----Original Message-----
From: Michael Keegan Code A
Sent: 23 Sep 2002 14:01
To: Paul Philip Code A Peter Swain Code A
Subject: Dr Barton

We have now received from Dr Simon Tanner, Director of Public Health at Hampshire and Isle of White Health Authority, a small file of correspondence, which was passed to the management of Fareham and Gosport Primary Care Trust by a member of staff on 16/9/02.

It includes copies of correspondence from the RCN Branch Convenor to various persons at the Trust and minutes and memoranda regarding meetings held with nursing staff to discuss their concerns about use of diamorphine in the unit.

I will provide copies of the same if you wish.

Michael.

Michael Keegan Code A

From: Michael Keegan Code A
Sent: 23 Sep 2002 10:06
To: Venessa Carroll Code A Peter Swain Code A
Subject: RE: Dr Barton

Juie Miller at CHI called this morning.

I informed her of the IOC's decision and she asked if we would be requesting discolsure of CHI's records on the subject. I said we or solicitors instructed for PCC preparation would be in touch if they were required.

Michael

-----Original Message-----
From: Venessa Carroll Code A
Sent: 23 Sep 2002 09:58
To: Michael Keegan Code A Peter Swain Code A
Subject: FW: Dr Barton

Mike Gill called again this morning to inform me that following the IOC's decision not to make an order, Dr Barton will be resuming practice on 30 September 2002. He has asked that the GMC consider the dossier and consider referring this back to IOC asap.

I think the dossier may be with Paul.

Thanks
Venessa

-----Original Message-----
From: Peter Swain Code A
Sent: 20 Sep 2002 17:02
To: Venessa Carroll Code A Paul Philip Code A
Cc: Michael Keegan Code A
Subject: RE: Dr Barton

It hasn't come to me (yet).

-----Original Message-----
From: Venessa Carroll Code A
Sent: 20 Sep 2002 16:40
To: Peter Swain Code A Paul Philip Code A
Cc: Michael Keegan Code A
Subject: Dr Barton

Paul and Peter

Mike Gill has just phoned to check whether we have received the dossier from the Health Authority. If you have received this could you please let me know so we can confirm receipt.

He also asked that once we have read the dossier the case be referred back to IOC. I said I would keep him informed of any developments.

Thanks
Venessa

Michael Keegan Code A

From: Vanessa Carroll Code A
Sent: 20 Sep 2002 16:41
To: Michael Keegan Code A
Subject: FW: Dr Barton

CMO

Michael

Could you please make a note to call Mike Gill when we have dossier and to also let him know if its to go back to IOC.

Vanessa

-----Original Message-----
From: Vanessa Carroll Code A
Sent: 20 Sep 2002 16:40
To: Peter Swale Code A ; Paul Philip Code A
Cc: Michael Keegan Code A
Subject: Dr Barton

Paul and Peter

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Thanks
Vanessa

I called Mike Gill 23/9/02 & confirmed receipt of Dr Simon Tennant's file & correspondence. I said I couldn't say if this would result in referral & says back to IOC but I would inform him when I was known.

He indicated that local action may be taken to suspend Dr Barton.

Code A

23/9/02

Michael Keegan Code A

From: Venessa Carroll Code A
Sent: 20 Sep 2002 16:41
To: Michael Keegan Code A
Subject: FW: Dr Barton

Michael

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Venessa

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Sent: 20 Sep 2002 16:40
To: Peter Swain Code A Paul Philip Code A
Cc: Michael Keegan Code A
Subject: Dr Barton

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Thanks
Venessa

I called Mike Gill 23/9/02 & confirmed receipt of Dr Simon Tanner's file of correspondence. I said I couldn't yet tell him if this would result in referral of case back to IOC but that I would inform him when I did know.

He indicated that local action may be taken to suspend Dr Barton.

Code A

23/9/02

Michael Keegan Code A

From: Michael Keegan Code A
Sent: 20 Sep 2002 09:17
To: Code A
Subject: Dr J A Barton

David,

Richard Clifford asked me to email you re: IOC referral for the above.

I can confirm that the IOC made no order.

Michael Keegan
Conduct Case Presentation Section
Code A

----Original Message-----
From: Richard Clifford Code A
Sent: 20 Sep 2002 09:05
To: Michael Keegan Code A
Subject: FW: Notification of IOC referral

Michael

See below. Yet another person at the DoH wanting to know the outcome of Baton's case.

Could you reply.

Richard

-----Original Message-----
From: Code A
[mailto: Code A
Sent: 20 Sep 2002 08:01
To: Code A
Cc:
Subject: Notification of IOC referral

IN CONFIDENCE

Richard

Thank you for the notification of IOC referrals dated 17th September.

I should be pleased if you would let me know the outcome of the hearing yesterday into the case of Jane Ann Barton.

David O'Carroll
Deputy Branch Head
Health Regulation Bodies Branch
Code A

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IOC Attendance Sheet C

Doctor present and represented by solicitor

Dr Barton is present and is represented by Mr Jenkins (Counsel), instructed by Mr Ian Barker of the Medical Defence Union

Miss Fiona Horlick Counsel, instructed by the Solicitor to the Council, represents the Council.

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Mrs A Macpherson

CASE OF: BARTON, Jane Ann

PROCEEDINGS

T.A. REED & CO.

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Mrs A Macpherson

CASE OF:

BARTON, Jane Ann

MS F HORLICK, Counsel, instructed by Messrs Field Fisher Waterhouse, Solicitors to the Council, appeared to present the facts.

MR A JENKINS, Counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

PROCEEDINGS

Transcript of the shorthand notes of T A Reed & Co,
13 The Lynch, Hoddesdon, Hertfordshire, EN11 3EU
Telephone No: 01992 465900

THE CHAIRMAN: Good morning everyone. May I formally open the proceedings. We move on to the case of Dr Barton. Dr Barton is present and is represented by Mr Jenkins, counsel, instructed by Mr Ian Barker of the Medical Union. Ms Fiona Horlick, counsel, instructed by solicitors to the Council, represents the Council.

Dr Barton, may I say first of all, I am conscious that you are currently on sick leave, and that you have recently undergone surgery. I do appreciate your being here today. If at any stage you feel you want a break, or need to take a temporary break, then please do not hesitate to say so. I do appreciate the fact that you have come along.

(Introductions made)

If there are no further points, then I will ask Ms Horlick to open the proceedings this morning, please.

MS HORLICK: This case involves the inappropriate prescribing to five patients at the Gosport War Memorial Hospital between February 1998 and October 1998, five patients whose ages range between 75 and 91, and who all died at the hospital. Dr Barton at the material time was a general practitioner and also a clinical assistant in elderly medicine at the hospital.

To give the Committee some idea of the history of the case, the police began an investigation into the circumstances of the death of one of those patients, Gladys Richards. That investigation later extended to four other patients. The Interim Orders Committee has considered this matter, as you have already said, on two occasions before. Firstly, June 2001, when it was considering only the matter of Gladys Richards and on that occasion no order was made.

In February 2002, the Crown Prosecution Service decided not to proceed with the criminal proceedings. Then the Crown's papers were disclosed to the General Medical Council and thus the matter came before the Interim Orders Committee again on 21 March this year, and again no order was made.

The present position as I understand it is that the Crown Prosecution Service is reconsidering their original decision and there always remains a possibility that there may be proceedings in relation to one or more of these patients. There has also been a PPC hearing which took place at the end of August this year. The PPC referred the matter on to the PCC but they made no interim order with regard to registration at that time.

THE CHAIRMAN: Sorry? They referred to the PCC?

MS HORLICK: They have, yes. So, in 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. Thus the matter has been referred to this Committee for its consideration today.

The information in relation to these matters is set out in pages 4, 5, 6, 7 and 8. I will come on to facts in relation to those five patients. You will also have within your

bundle, inter alia, a report from Professor Ford, and I am going to refer to some of his conclusions whilst dealing with each of the patients.

May I deal first with the patient Eva Page. She was admitted to the Dryad Ward which was one of the wards in which Dr Barton worked on 27 February 1998. She came under the care of Dr Barton. She was there for palliative care. She had a possible carcinoma of the bronchus. She died on 3 March 1998. She was 87 years old. She had originally been admitted to the Queen Alexandra Hospital on 6 February 1998, after her condition deteriorated over the preceding five days.

On 7 February 1998, she was noted to have a low mood, to be frightened and X-rays showed a potentially malignant mass superimposed on the right hilum. On 12 February 1998 a management plan was set up, which was to give palliative care in view of her advanced age. On 16 February 1998, there was a gradual deterioration in her condition. She had no pain but she was confused and she was continued on antidepressants. It was on 27 February, as I have said, that she was transferred to the ward and came under the care of Dr Barton. On the day that she was transferred, Dr Barton wrote in the medical notes that she was transferred to Dryad ward, continuing care. Diagnosis of carcinoma of bronchus, CXR on admission.

> "Generally unwell, off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking; needs hoisting; Barthel – 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing staff to confirm death."

The nursing notes confirm that she had been admitted for palliative care.

On 28 February 1998, she was noted to be not in pain. She was administered Thioridazine and Oramorph. She was distressed.

On 2 March 1998, she was noted to be very distressed and Dr Barton noted that adequate opioids to control should be administered. She had fear and pain. Therefore 5 mg of diamorphine was administered by a syringe driver.

On 3 March 1998, a rapid deterioration of her condition is noted. Diamorphine, Midazolam was commenced by syringe driver. It is this prescription which is the subject of criticism by Professor Ford. She died on that day, death being recorded at 21:30. His criticism is that there was no indication that Eva Page was in pain or distress, and with a frail, elderly and underweight patient that prescription was potentially very hazardous and poor practice, but he concluded that it was probably for palliative reasons that it had been prescribed by Dr Barton.

Dr Mundy is another doctor who has made a report in this case and in relation to this case, he concluded that Mrs Page had a clinical diagnosis of lung cancer.

THE CHAIRMAN: Is there a page number?

MS HORLICK: I am sorry, madam. It is page 57.

> "There was no documentation of any pain experienced. 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 symptom control and she was started on opioid analgesia, in my view, inappropriately."

He comments:

> "The prescription for subcutaneous diamorphine infusion again showed a tenfold range from 20 mg to 200 mg."

In his conclusion is:

> "The reason for starting opioid therapy was not apparent in several of the cases concerned."

That is the conclusion overall. Can I deal secondly with Alice Wilkie. She died on 21 August 1998. She was 81. She had been admitted on 6 August 1998 to the Daedalus ward where Dr Barton worked. She had been admitted to that ward for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection. In fact, she had been admitted to the Queen Alexandra Hospital on 31 July 1998. She was found to have a fever. She was given intravenous antibiotics. By 3 August the fever had settled and she was improving. She had severe dependency needs but on transfer to the Daedalus ward it was noted that her bed should be kept at her care home.

The nursing notes state that she was transferred to the Daedalus ward for a four to six week assessment and observation and then a decision would be taken about placement. In other words, it was intended that she would leave Daedalus ward to go back to some form of care home.

On 10 August it was noted that she was eating and drinking better and that she would be reviewed in one month, and if there was no specific special medical or nursing problem she would be discharged.

The next entry in the notes is by Dr Barton on 21 August.

THE CHAIRMAN: Can we have a page, please?

MS HORLICK: Page 79. There it is noted by Dr Barton:

> "Marked deterioration over last few days. Subcutaneous analgesic commenced yesterday. Family aware and happy."

A final entry on the same day is at half past six in the evening when death is confirmed but there had been no entry that Mrs Wilkie had been in pain on 20 August or in the preceding days, and no analgesic drugs had been administered to her before. It appears that Dr Barton had prescribed a regular daily prescription of diamorphine, 30 mg over 24 hours, and Midazolam, 20 mg over 24 hours. That had been started to be prescribed to Mrs Wilkie from 13:50 on 20 August, therefore the day before she

A died. They were administered to her again on 21 August. There was no indication for the use of those drugs, no explanation as to why, and Professor Ford notes that it was poor practice, potentially very hazardous in a frail, elderly and underweight patient, and it could result in profound respiratory depression, and her death was possibly due, at least in part, to respiratory depression from the diamorphine, or that diamorphine led to the development of bronchopneumonia.

B Dr Mundy comments on this patient at page 55 of the bundle. He said:

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

Can I now turn to the matter of Gladys Richards, which was the matter originally investigated by the police. Madam, I am looking here at page 62.

She had been 91 years old when she was admitted as an emergency to the Haslar Hospital on 29 July 1998. She fractured the right neck of her femur. She had
D dementia. There had been a deterioration in the quality of her life over the previous six months. She had surgery for the fracture on 30 July 1998 and she was then referred to Dr Reid, who is a consultant physician in geriatrics on 3 August 1998. He concluded that despite dementia, she should be afforded the opportunity to remobilise her.

On 10 August 1998, just prior to her transfer to the Daedalus ward, it was noted:
E

> "[She] is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated a meantime she want the toilet. Occasionally incontinent at night, but usually wakes."

F The following day, 11 August, she was transferred to the Daedalus ward. On that date, Dr Barton had written in the medical notes.

> "Impression frail demented lady, not obviously in pain, please make comfortable. Transfers with hoist, usually continent, needs help with ADL Barthel 2. I am happy for nursing staff to confirm death."

G The nursing notes recall that she is now fully weight bearing and walking with the aid of two nurses and a Zimmer frame. However, on 12 August, the notes recorded that a little before midnight she had been very agitated, shaking and crying. Did not settle for more than a few moments. However, she did not seem to be in pain.

It seems the following day that she had been found on the floor at 13:30. No injury was apparent at the time but her right hip was internally rotated, and another doctor
H had been contacted for an X-ray.

On 14 August, Dr Barton had noted that sedation and pain relief had been a problem. Screaming was not controlled by haloperidol but very sensitive to Oramorph. Dr Barton had also proposed the rhetorical question, "Is this lady well enough for another surgical procedure?" It seems that she was, because she was readmitted to the Haslar Hospital. The hip was manipulated under sedation, and that was successful. She was discharged back again to the Daedalus ward on 17 August. Again it was noted that although she had been given a canvas knee-immobilizing splint which must stay in situ for four weeks, she could however mobilise full weight bearing. But the nursing notes on that day record that when she had been transferred back she had been very distressed and appeared to be in pain. Later that day, she had been given Oramorph 2.5 mg in 5 ml. A further X-ray was performed which demonstrated no fracture, so that was not the source of the pain. Pain demonstrated. Dr Barton had also noted that on 17 August, the day of transfer back, she had been under i/v sedation during the closed reduction. She remained unresponsive for some hours and –

> "... now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again."

On 18 August, it was noted she was still in great pain, nursing a problem.

> "I suggest subcutaneous diamorphine, haloperidol/Midazolam. I will see daughters today. Please make comfortable."

The nursing notes say that she had been reviewed by Dr Barton for pain control via syringe driver. It was further noted that she reacted to pain when being moved.

On 19 August, the nursing notes recorded that she was comfortable and she was apparently pain free. There appear to be no notes at all for 20 August, but the next entry is Dr Barton's on 21 August, where she records:

> "much more peaceful. Needs hyoscine for rattly chest."

She recorded as her overall condition deteriorated.

> "Medication keeping her comfortable."

The time of death is recorded as being 21:20 later that day. The cause of death was recorded as bronchopneumonia.

One can see set out on page 64 the dates and times of the various medication and opiates that were given to her during her time on the ward.

Dr Barton's treatment is criticised by Professor Ford. He says that even in a woman of Mrs Richard's age, there were good reasons to offer surgery for the fractured neck of the femur because without it, the patient remains immobile and nearly invariably develops serious and usually fatal conditions. He notes that Dr Reid believes that she had potential to benefit from rehabilitation, and that would have been implicit in her transfer to the Gosport War Memorial Hospital to receive rehabilitation there. It seems that Dr Barton did not appreciate that that was the reason for her rehabilitation and one knows from the papers that Dr Barton made a statement to the police. She

A was asked about her entry on initial transfer to the Daedalus ward, the entry which said, "I am happy for nursing staff to confirm death," when Mrs Richards had been apparently transferred from rehabilitation. Dr Barton told the police that she appreciated there was a possibility that Mrs Richards might die sooner rather than later, and regarded the admission as a holding manoeuvre.

B Professor Ford sets out reasons why Dr Barton's approach to Mrs Richards might well have been different to Dr Reid's. He concludes at the end of paragraph 2.18 that Dr Barton's experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

C In paragraph 2.19, he sets out Dr Barton's explanation for the administration of drugs to Mrs Richards. He criticises some of her conclusions. He says that screaming is a well-described behavioural disturbance in dementia. It can be due to pain, but is often not. He concludes that there was not a proper clinical examination of the reason for the screaming because of course, he says, if the screaming had been worse on weight bearing or on movement, that would have provided supportive evidence that screaming was from pain, as opposed to dementia.

D He notes that Mrs Richards had not been prescribed opiates before she was transferred to the Daedalus ward, he says:

> "This makes me consider it probable that Dr Barton prescribed ... Oramorph, diamorphine, hyoscine, and Midazolam when she first saw Mrs Richards and she was not in pain."

He said:

E

> "I do not consider it appropriate to administer intermittent doses of Oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. ... Dr Barton's statement that diamorphine and Oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians."

F He also criticises the fact that there are no notes of fluid or food intake after Mrs Richards was readmitted to the Daedalus ward on 17 August, and between that and her death on the 21st. He says that although there were no clear descriptions of her conscience level in the last few days, her level of alertness appears to have deteriorated once the subcutaneous infusion of diamorphine, haloperidol and Midazolam was commenced. It seems that she was not offered fluids or foods, and

G intravenous or subcutaneous fluids were not considered as an alternative. He says the decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards on initial admission to the Daedalus ward was, in his opinion, inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression.

H The prescription of oral paracetamol and my Lady opiates would have been appropriate and would have had a better risk/benefit ratio. The prescription of

subcutaneous diamorphine, haloperidol, and Midazolam infusions "to be taken if required" was inappropriate even if she was experiencing pain. It goes on to explain why. He says:

> "The prescription by Dr Barton on 11 August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards at serious risk of developing coma and respiratory depression had these been administered by the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effect on conscious level and respiration to frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry is high risk of producing respiratory depression or coma"

He goes on in paragraph 2.27 to consider Dr Barton's statement in relation to the use of Midazolam which he said was inappropriate.

Dr Barton made a statement to the police in relation to this matter which is in your bundle. At the end of it, she says ---

THE CHAIRMAN: Page number, please? Is it page 153?

MS HORLICK: It is page 153 – thank you, madam. At the end of that, at page 162, paragraph 38, she says:

> "At no time was any active treatment of Mrs Richards conducted with the aim of hastening her demise. My primary and only purpose in administering the diamorphine was to relieve the pain which Mrs Richards was suffering. Diamorphine can in some circumstances have an incidental effect of a hastening a demise but in this case I do not believe that it was causing respiratory depression and was given throughout at a relatively moderate dose."

At paragraph 39, she says similarly:

> "Similarly it was not my intention to hasten Richards' death by omitting to provide treatment for example in the form of intravenous or subcutaneous fluids. By the 18th August it was clear to me that Mrs Richards was likely to die shortly."

She did not believe that transfer to another hospital would have been in her best interests.

I now turn to Mr Cunningham. Mr Cunningham was 79 years old. He had had Parkinson's disease since the mid-80s. By July 1998, he had Parkinson's disease, dementia and depression. When he was seen on 21 September 1998 in the Dolphin Day Hospital by Dr Lord, she recorded that he was very frail, tablets had been found

in his mouth, he had a large necrotic sacral sore with thick black scar. His Parkinson's disease was no worse.

THE CHAIRMAN: Is this page 72?

MS HORLICK: It is, madam, yes. He decided to transfer him to do Dryad ward on that day. The entry by Dr Barton on 21 September says:

> "Make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death."

She decided to prescribe and administer diamorphine and Midazolam by subcutaneous infusion on the evening of 21 September, so the evening of the day that he was admitted. Professor Ford's opinion of that, at paragraph 3.10 was that he considered 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"

– apparently underlined –

> "doses of Oramorph earlier in the day. I consider the undated prescription by Dr Barton of subcutaneous diamorphine..."

and he gives the amounts –

> "to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and Midazolam in a frail elderly underweight patient such as Mr Cunningham. The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing Midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case."

Apparently it had been prescribed and administered for pain relief and to allay anxiety but there was no clear recording that Mr Cunningham was in pain or, indeed, where the site of the pain was, if it existed.

On 23 September, it was noted that he had been chesty overnight and deteriorated. Professor Ford's conclusion is:

> "The symptoms could have been due to opiate and benzodiazepine induced respiratory depression. The family were told that Mr Cunningham was dying."

But on 24 September 1998, Dr Lord reviewed him and he was apparently in pain. On 25 September dosages were increased threefold. There was no record of Mr Cunningham receiving food or fluids since his admission to the Daedalus ward on

A the 21st despite the fact that Dr Lord had prescribed a high protein diet for him when she transferred him to the Dryad ward. He died on 26 September, a little before midnight. The cause of death was recorded as bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer.

Professor Ford was also concerned about the initial note entered by Dr Barton on 21 September, that she was happy for nursing staff to confirm death, because – as he B says – there was no indication by Dr Lord that Mr Cunningham was expected to die"

THE CHAIRMAN: I am sorry to interrupt. I am slightly confused because on page 72, it is suggested that Dr Lord had made that entry. I take it you are saying that that is wrong. It is paragraph 3.2.

MS HORLICK: I think there had been a further entry by Dr Lord on the 21st, saying C that she was happy for nursing staff to confirm death. It was when Mr Cunningham was admitted to the Dryad ward on 21 September, having seen Dr Lord in the Dolphin Day Hospital. It was on that day that Dr Barton was recording, "Am happy for nursing staff to confirm death."

THE CHAIRMAN: I am sorry. I see they are both recorded.

D MS HORLICK: Yes. I think Professor Ford's point was that there was no indication on the day that he was first admitted that there would be any indication of death ensuing in the near future. Professor Ford notes that it is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present, or from the combined effect of bronchopneumonia and drug induced respiratory depression as a result of the drugs which had been prescribed to him.

E Dr Mundy comments upon Mr Cunningham's case at page 54. He says:

> "All the prescriptions for opioid analgesia are written in the same hand and I assume they are Dr Barton's prescriptions ... 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 doses of oral morphine, the 24 hour dose requirement of F diamorphine could not therefore be established. The dose of diamorphine prescribed gave a tenfold range from 20 mg to 200 mg in 24 hours which is an unusually large dose range in my experience."

- just in parenthesis, one which is common to Dr Barton's prescriptions in all these cases.

G "The patient was reviewed by Dr 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 40 mg 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."

H

Lastly, might I turn to Robert Wilson. I will be referring to notes on page 83. Mr Wilson was a 75 year old man. He had been admitted to the Queen Alexandra Hospital on 22 September 1998. He had a fracture of the left humerus. Morphine had been administered to him intravenously and then subcutaneously but he developed vomiting. Two days later, when he was given 5 mg of diamorphine he had lost sensation in the left hand. Five days later, it was noted that he had poor quality of life and poor prognosis, and he was not to be resuscitated.

However, by 7 October he had apparently stated that he did not want to go to a residential home and wanted to go home. Although he had previously been sleepy, withdrawn and in a low mood, when he was seen by Dr Lusznat, the consultant in old age psychiatry on 8 October, he was much better. He was eating and drinking well, and appeared brighter in mood. His Barthel score was 5/20. It was noted that he had been a heavy drinker over the previous five years and that he had possible early dementia, Alzheimer's disease or possible vascular dementia.

On 13 October it was noted that he required both nursing and medical care. He was at risk of falling and that what would be appropriate would be a short spell in long-term NHS care.

On 14 October he was transferred to the Dryad ward. An entry on the same date by Dr Barton reads:

> "Transfer to Dryad ward continuing care. HPC fracture humerus, needs help with ADL ... hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation."

I think here it is recorded as being 16 November, but that must be wrong because he had died by then. On 16 October, the notes record that he declined overnight, and gave details of that. He had a possible silent myocardial infarction and Dr Barton had written a prescription for subcutaneous diamorphine, hyoscine and Midazolam and that was administered to him on 16 October. Again, this is a course of action criticised by Professor Ford.

I am looking at paragraph 5.12. He says:

> "I am unable to establish when Dr Barton wrote the prescription .... as these are undated. 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. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following myocardial infarction is appropriate standard practice but was not indicated in Mr Wilson's case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Mr Wilson was not administered intravenous frusemide or another loop diuretic."

He says it is an inadequate response to Mr Wilson's deterioration.

In the following 48 hours, the increase of diamorphine was from 40 mg/24 hours and then 60 mg/24 hours. At paragraph 5.13, Professor Ford says that that increase was not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time.

> "This was poor practice and potentially very hazardous. Similarly the addition of Midazolam and subsequent increase in dose to 40 mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive."

He notes that there were no justifications for those increases in those three drugs written in the medical records.

On 17 October, Mr Wilson was noted to have deterioration variously described in one place as rapid and another place as slow, but on 18 October there had been a further deterioration and his death was recorded at 23:40 that night.

Dr Mundy again comments on this case at page 56. He says:

> "Mr Wilson was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given..."

and he notes that there was an entry earlier in the episode of care that Mr Wilson had refused paracetamol.

> "No other analgesia was tried prior to starting morphine."

He notes that once again, the diamorphine prescription had a tenfold dose range as prescribed. He also considered that the palliative care given was appropriate.

Professor Ford, on page 53, sets out sets out the appropriate use of opioid analgesics. He says:

> "Opioid analgesics are used to relieve moderate to severe pain and also can be used to relieve distressing breathlessness and cough. The use of pain killing drugs in palliative care (ie the active total care of patients whose disease is not responsive to curative treatment) is described in the British National Formulary which is the standard reference work circulated to all doctors in Great Britain."

THE CHAIRMAN: I have not interrupted you before but...

MISS DOIG: It is surely Dr Mundy?

MS HORLICK: Dr Mundy, yes.

THE CHAIRMAN: I have let you go to some detail in the cases you have gone through, but I think you can assume that we have read the papers. I think if you could perhaps summarise rather than read the papers it would be helpful, and just pick out the points you think are particularly worth stressing.

MS HORLICK: Dr Mundy, as I am sure you have read, sets out the way that treatment should be given, and what should be tried before going on to a further treatment. His conclusion in relation to these cases can be found at page 57:

> "The reason for starting opioid therapy was not apparent in several of the cases concerned."

They had not been given for long enough to ascertain the appropriate dose. Professor Ford also draws conclusions at the end of his report at page 59. He makes certain criticisms of Dr Barton's prescribing at the end of that report, and as detailed in the middle of it, as I have already set out.

THE CHAIRMAN: I think his conclusions are at page 93 and 94.

MS HORLICK: Yes, they are. Thank you, madam. Just to bring matters up to date, there is a letter from Dr Barton's solicitors which can be found at page 404, from the Medical Defence Union. That letter sets out in some detail Dr Barton's response to these allegations which I am sure the Committee has read. It is obvious that Dr Barton has ceased to provide medical care for the adult patients in the hospital, and she has voluntarily stopped prescribing opiates and benzodiazepines. As I said at the beginning, these matters have been considered before but the change in circumstances is the possible reconsideration of the matter by the Crown Prosecution Service, and the fact the matter has gone to the Professional Conduct Committee for their consideration.

THE CHAIRMAN: Do you have any recommendations?

MS HORLICK: No, madam.

THE CHAIRMAN: Can I just be quite clear about the sequence of events here? You referred to two previous IOC hearings?

MS HORLICK: Yes.

THE CHAIRMAN: Am I right, the first one, I think you said, was in June 2001, and only considered the case of Gladys Richards?

MS HORLICK: That is right, yes.

THE CHAIRMAN: The second one in March this year, did it consider all five cases?

MS HORLICK: Yes, it did.

THE CHAIRMAN: And the PPC hearing on 29 August, did they consider all five cases and the papers that we have today?

MS HORLICK: As far as I am aware, yes.

THE CHAIRMAN: And the referral back to the IOC now did not come from the PPC?

MS HORLICK: No, madam.

THE CHAIRMAN: It came from the President?

MS HORLICK: That is right.

THE CHAIRMAN: And you are saying it is because the CPS have now re-opened. I forget your wording.

MS HORLICK: They are reconsidering their original decision not to pursue the criminal ---

THE CHAIRMAN: But we have no papers to give us confirmation of that, or to give us any further... I am just trying to be clear how the situation has changed. So the only change has been that we have information, we know not how we got it, that the CPS are reconsidering.

MS HORLICK: That is right, although, as I am sure Mr Jenkins will tell you, the defence have been in contact with the officer in the case who is happy with the original decision that was taken by the Crown Prosecution Service not to proceed with the criminal proceedings. But, of course, it is not a decision which is taken by the police. It is a decision which is taken by the Crown Prosecution Service, whether to institute or discontinue proceedings.

THE CHAIRMAN: We do not know why the situation has changed?

MS HORLICK: My understanding is that the families of the patients involved were unhappy about the decision which was originally taken. You will notice in your bundle that they have written letters directly in the very recent past to the General Medical Council, to make complaints about the way that their parents were treated. I think, to be fair to Dr Barton, there has been a degree of pressure brought upon the Crown in this case to reconsider the matter.

THE CHAIRMAN: That is helpful. Did you want to say anything?

THE LEGAL ASSESSOR: Is there no additional material or evidence since the last hearing of the IOC?

MS HORLICK: As far as I understand it, there is no additional material.

THE CHAIRMAN: Most unusual circumstances. Does any other member wish to raise any points of clarification? (No reply) I just wonder whether the Committee ought to have a brief in camera session before we go further.

THE LEGAL ASSESSOR: I wonder whether Mr Jenkins has anything to say about this?

MR JENKINS: Can I help you. It may be, after I have made the few remarks that I have to say, that may assist a short in camera deliberation.

Mr Barker, who sits besides me, who is the author of the letter that you see at page 404, setting out observations on behalf of Dr Barton, two days ago spoke to Chief Superintendent Watts, who is the head of CID with the Hampshire constabulary. He is coordinating the police investigation into these five cases. He is an experienced police officer. He has been producing a guide for police generally, investigating cases of alleged medical manslaughter. He is not a police officer who has no experience of looking at this sort of investigation, this sort of case.

The police originally investigated the case of Mrs Richards and you will see a reference, I think on page 13 of the bundle, to a letter to the GMC in August 2001, that Senior Treasury Counsel – that is a senior criminal barrister – was asked to look at the case and the evidence in relation to Mrs Richards. The advice provided to the Crown Prosecution Service, which informed the police decision, was that there was case to be prosecuted.

Police subsequently looked into the other four cases and the view that they took was that those cases raised similar issues to that of Mrs Richards. In their analysis – this comes from the attendance note of a telephone conversation between Mr Barker and detective Chief Superintendent Watts. The police analysis of those other cases was that it was the same, or raised the same issues as those that were raised in the case of Mrs Richards, and upon that basis the police took the view that there was no case to be raised against Dr Barton. Subsequently there have been, as my learned friend has suggested, concerns raised on behalf of family members, relatives and the police have decided to send the case papers to the CPS. They have not yet gone. The understanding that Mr Barker got from the conversation was that this was a case of back-covering – I can use that expression – by the police. The police were perfectly satisfied. They had no concerns. Because of concerns raised by family members, they thought, "We will get the CPS to check," and that is the basis upon which papers have been sent to the CPS. There is no new evidence. There are no fresh allegations, there is nothing else that the police have sent on to the CPS, essentially other than the papers that you have seen. Those are the same papers that were seen by the earlier Committee this year. Nothing – nothing – in reality has changed.

There is a lot more I would like to say if the Committee were going on to consider whether to impose conditions or other matters, but you have suggested you might want to deliberate shortly in camera.

THE CHAIRMAN: First of all, can I comment and then ask the Legal Assessor. We certainly have precedents where the Committee considered at this stage whether they wish to continue to hear further evidence. It strikes me, in view of what we have heard, that this might be a case where I should deliberate with the Committee to see if they wish proceed with the remainder of the full hearing, if I can put it like that.

MR JENKINS: Indeed.

THE CHAIRMAN: Legal Assessor, do you wish to comment?

THE LEGAL ASSESSOR: All I was going to say is this. Do you have any comments on the propriety - not the power but the propriety - of this Committee to consider again a matter on which the Committee has already decided without any fresh evidence at all?

In normal circumstances, you would say, if you like, it is res judicata, and I doubt whether that doctrine strictly applies to this Committee, but it may be something which the Committee should take into account.

MR JENKINS: The normal circumstance in which a case might be reconsidered is if there is some fresh evidence or change of circumstances. It is advanced by my learned friend that there is a change of circumstances because this case has been referred by the Preliminary Proceedings Committee to the Conduct Committee and also the papers have now been sent to the CPS. I say those are somewhat manufactured as a change of circumstances. It is not a real change of circumstances. If there was further evidence or if there was another basis of concern about Dr Barton's practice, then that might alter matters. To the extent that the Committee may be concerned that they are invited to review an earlier decision, I agree entirely with the suggestion that they should decline to do so. I know at least one member of your Committee today was on the Committee that considered the case last time. That is Mr Winton. It seems a little strange that he should be invited to review the decision that the Committee he sat on then looked at.

I am prompted – the suggestion of back-covering is not an appropriate one. The police would not agree it, but that may be the effect of what is happening. The police were satisfied. They conducted their own inquiry. These are experienced police officers who are familiar with the concept of the gross negligence/manslaughter in a medical context. They did not see the need themselves to send the case to the CPS for further investigation. They have now done so because of concerns raised by the family, but there is no fresh evidence to place before the CPS.

I do not know that that answers the point. It is a response.

THE LEGAL ASSESSOR: I think it suggests that your thoughts are rather similar to my thoughts. I would really advise the Committee that without fresh material it would be only in extreme circumstances that the matter should be reconsidered again. I do not see evidence that there are such extreme circumstances. It could be that if the Preliminary Proceedings Committee had referred it here as part of their process of sending it to the Professional Conduct Committee that would be a factor which this Committee could take into account, but that is not the situation.

MR JENKINS: The generality of the position is the same as it was before. Dr Barton has, as you know, retired or resigned the job she held at the Gosport War Memorial Hospital back in 2000. You will have seen reference to correspondence in the transcript last time that she resigned because she felt she was under-resourced and could not do the job properly. That position clearly still holds. She is not in a position where she is dealing with those who are terminally ill or in the very last stages of their life. She continues to work full time as a GP subject to other matters. She does not routinely prescribe benzodiazepines or opiates.

The condition to which she agreed with the Health Authority - 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 as far as circumstances changing since the last hearing before the IOC, 21 March 2002, I think that is the only change. I am sorry: the

condition that she did not prescribe benzodiazepines or opiates was lifted by the Health Authority.

THE CHAIRMAN: Ms Horlick, do you want to make any comment on the last few exchanges?

MS HORLICK: Madam, no.

THE CHAIRMAN: I think we should go into camera. As I see it, there are two issues here. One is whether there is new evidence since the last IOC hearing which justifies this Committee hearing the case afresh. The evidence is simply that we have heard that the CPS are reopening. The second, I think, is simply that the PPC have referred the case to the Professional Conduct Committee. That is the new evidence bit. If we decide that this is a full hearing and we are considering matters, then it is within our gift, and we certainly have precedent, that we can make a decision on the case if we feel minded to do so without hearing the full defence submission.

MR JENKINS: Thank you. I can tell you, if you were to ask for my submissions, they would be brief. I would be reminding you of what appears in the letter at page 404, and the transcript of the evidence that Dr Barton gave on the last occasion. I know you a familiar with them.

THE CHAIRMAN: Thank you, Mr Jenkins. We will go the to camera. If it looks like we are going to be taking a lunch break before we conclude, then we will let you know, but I am not saying that at the moment.

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

PARTIES HAVING BEEN READMITTED

THE CHAIRMAN: Before I read the determination, I am going to ask the Legal Assessor to repeat the advice he gave us in camera.

THE LEGAL ASSESSOR: I advised the Committee that in light of the fact that there was no new evidence before them it would be unfair to the doctor for the Committee to consider the matter any further.

DETERMINATION

THE CHAIRMAN:

Dr Barton: The Committee has carefully considered the information before it today and has determined that it is not necessary for the protection of members of the public, in the public interest or in your own interests that an Order under Section 41A

of the Medical Act 1983, as amended, should be made in relation to your registration whilst the matters referred to the GMC are resolved.

The view of the Committee is that there is no new material in this case since the previous hearing of the Interim Orders Committee on 21 March 2002. The Committee has reached this determination in the light of this and the Legal Assessor's advice.

That concludes the case for this morning. Thank you for coming. I hope it has not impeded your convalescence too much. I appreciate it is stressful for you.

IOC REFERRALS

DOCTORS FULL NAME :	**Barton, Jane**
FPD REFERENCE :	**2000/2047**
TYPE OF CASE : (Performance/Health/Conduct)	**Conduct**
CASE WORKER :	**Venessa Carroll/Michael Keegan**
DOCTOR'S PLACE OF PRACTICE :	**Gosport**
DOCTORS SPECIALTY :	**GP**
DATE COMPLAINT RECEIVED :	**July 2000**
DATE OF REFERRAL TO IOC :	**13 September 2002**
REFERRED BY :	**The President**
MEMBER(S) THAT HAVE SEEN CASE	**Screener: Dr Malcom Lewis** **PPC:** Mr Bob Nicholls, Professor Roger Green, Dr Richard Kennedy, Sir Roddy MacSween and Professor Nigel Stott, Dr Sheila Mann **Please note this case has twice been before IOC**
IS DOCTOR CURRENTLY PRACTISING :	**Yes**

SUMMARY OF ALLEGATIONS :

Inappropriate prescribing to elderly patients – suggestion that death precipitated if not caused by prescribing

TELEPHONE MESSAGE PAD

FROM .....

TO .....

TIME/DATE 19.9.02

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dr Barton

HC's → ① Mike Gill (Reg. Dir. of P.H.)

& ② Simon Tanner (Director of P.H. @ Portsmouth H.A.)

① Told him that IOC made no order today.

② Left message for him to call me back.

→ Did so → Told him.

Code A

19.9.02

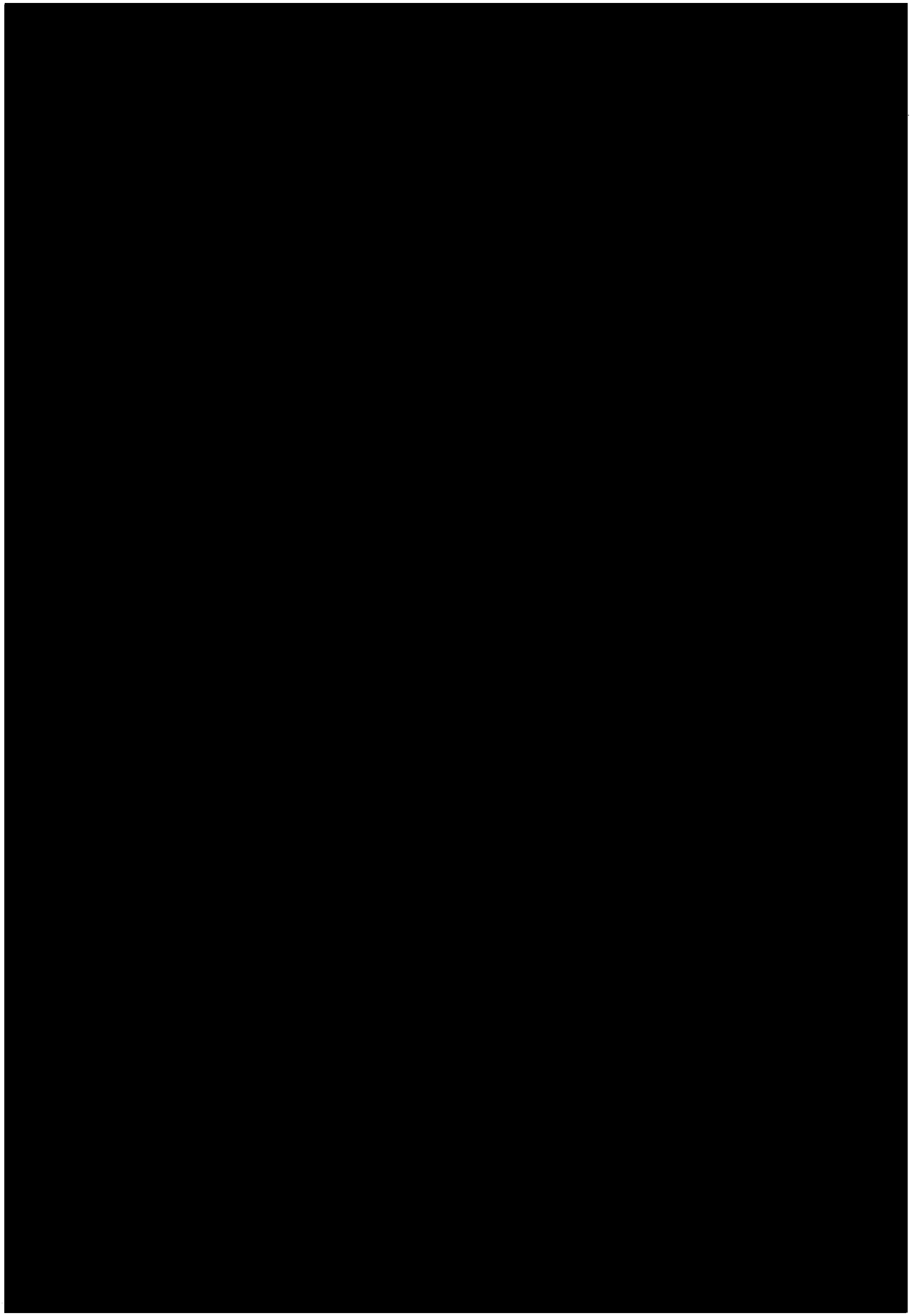
Message taken by .....

Dr Barton

IOC 19 September 2002

Dr Barton: The Committee has carefully considered the information before it today and has determined that it is not necessary for the protection of members of the public, in the public interest or in your own interests that an Order under Section 41A of the Medical Act 1983, as amended, should be made in relation to your registration whilst the matters referred to the GMC are resolved.

The view of the Committee is that there is no new material in this case since the previous hearing of the Interim Orders Committee on 21 March 2002. The Committee has reached this determination in the light of this and the legal assessor's advice.



Please quote our reference when communicating with us about this matter

Our ref: ISPB/sls/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
17 September 2002

Ms Vanessa Carroll
Assistant Registrar
General Medical Council
178 Great Portland Street
London
W1W 5JE
Also by fax: 0207-915-7406

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

Dear Ms Carroll

Interim Orders Committee - Dr Jane Barton

I write with reference to your letter to my client, Dr Barton, of 13 September 2002.

With reference to the Rule 11 of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000, I would be grateful if you would kindly make available to me all documents in this matter as a matter of urgency. In particular, I would be grateful for sight of any communications between the Council and the Department of Health whether in letter form or notes of telephone communication.

Yours sincerely

Code A

THE MDU

The Medical Defence Union Limited
Legal Department

Facsimile

To:	Ms Vanessa Carroll
Company:	General Medical Council
Fax no:	**Code A**
From:	Ian Barker
Date sent:	17 September 2002
Time sent:	
No. of sheets inclusive:	2
Re:	**Jane Barton**

If you do not receive legible copies of all the pages please notify us immediately by telephone or fax.

Privacy & Confidentiality Notice
This facsimile may contain privileged and confidential information intended for the named recipient only. If you have received this facsimile in error please notify us immediately by telephone.

Please quote our reference when communicating with us about this matter

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Your ref: ACE/HJ/FPD/2000/2047
17 September 2002

Ms Vanessa Carroll
Assistant Registrar
General Medical Council
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W1W 5JE
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Dear Ms Carroll

Interim Orders Committee - Dr Jane Barton

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Yours sincerely

Code A

E:\Conduct Case Presentation\Richard Clifford\ioc\notification to doh letter barton, abraham, selvaraj.doc

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Your reference

In reply please quote RC/FPD/1998/0869, 2001/1393 & 2000/2047

Please address your reply to the Conduct Case Presentation Section FPD
Fax 020 7915 3696

17 September 2002

Mr Martin Sturges
NHS Executive Headquarters
Department of Health
Quarry House
Quarry Hill
Leeds LS2 7UE

Dear Mr Sturges,

Notification of IOC referral

At its meeting on 29-30 August 2002 the GMC's Preliminary Proceedings Committee (PPC) referred the following doctors to the Interim Orders Committee (IOC):

[redacted]

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

[redacted]

The President of the GMC has also referred the following doctor to the IOC:

BARTON, Jane Anne

Registration no: 1587920

Registered address: Code A
Code A

Specialty: General Practice

Employer: Hampshire and Isle of Wight Practitioner and Patient Services Agency

Type of case: Inappropriate/irresponsible prescribing

In each case, the IOC will consider whether it is necessary for the protection of members of the public, or is otherwise in the public interest, or in the doctor's own interests, that an interim order should be made suspending his or her registration or imposing conditions on his or her registration.

[redacted]

Please let me know if you require any further information.

Yours sincerely

Code A

Richard Clifford
Conduct Case Presentation Section

Code A

TRANSMISSION VERIFICATION REPORT

TIME : 17/09/2002 16:53
NAME : GMC
FAX : 020-7915-3696
TEL :

DATE,TIME	17/09 16:52
FAX NO./NAME	901962871244
DURATION	00:00:30
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

Fax

To C S J James

Fax number Code A

From Michael Keegan

Direct Dial Code A

Direct Fax

No. of pages (inclusive) 2 16:45 Date 17 September, 2002

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Please see attached letter.

Your reference: Chief Supt/JJ/DM
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

17 September, 2002

Also by fax: 01962 871 244

Chief Superintendent J James
Hamspshire Constabulary
Police Headquarters
West Hill
Romsey Road
Winchester
Hampshire
SO22 5DB

Dear C S James

Further to my letter of 12 September 2002 (in which I referred to you as C I James, and for which I apologise) I write now to inform you, in confidence, that the President of the GMC has also referred Dr Barton to the Interim Orders Committee, which is scheduled to consider the matter this Thursday, 19 September 2002.

In light of this and telephone messages received about the reopening of your inquiries, I should be grateful for a very brief summary of current state of police investigations into events at the Gosport War Memorial Hospital as soon as possible.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

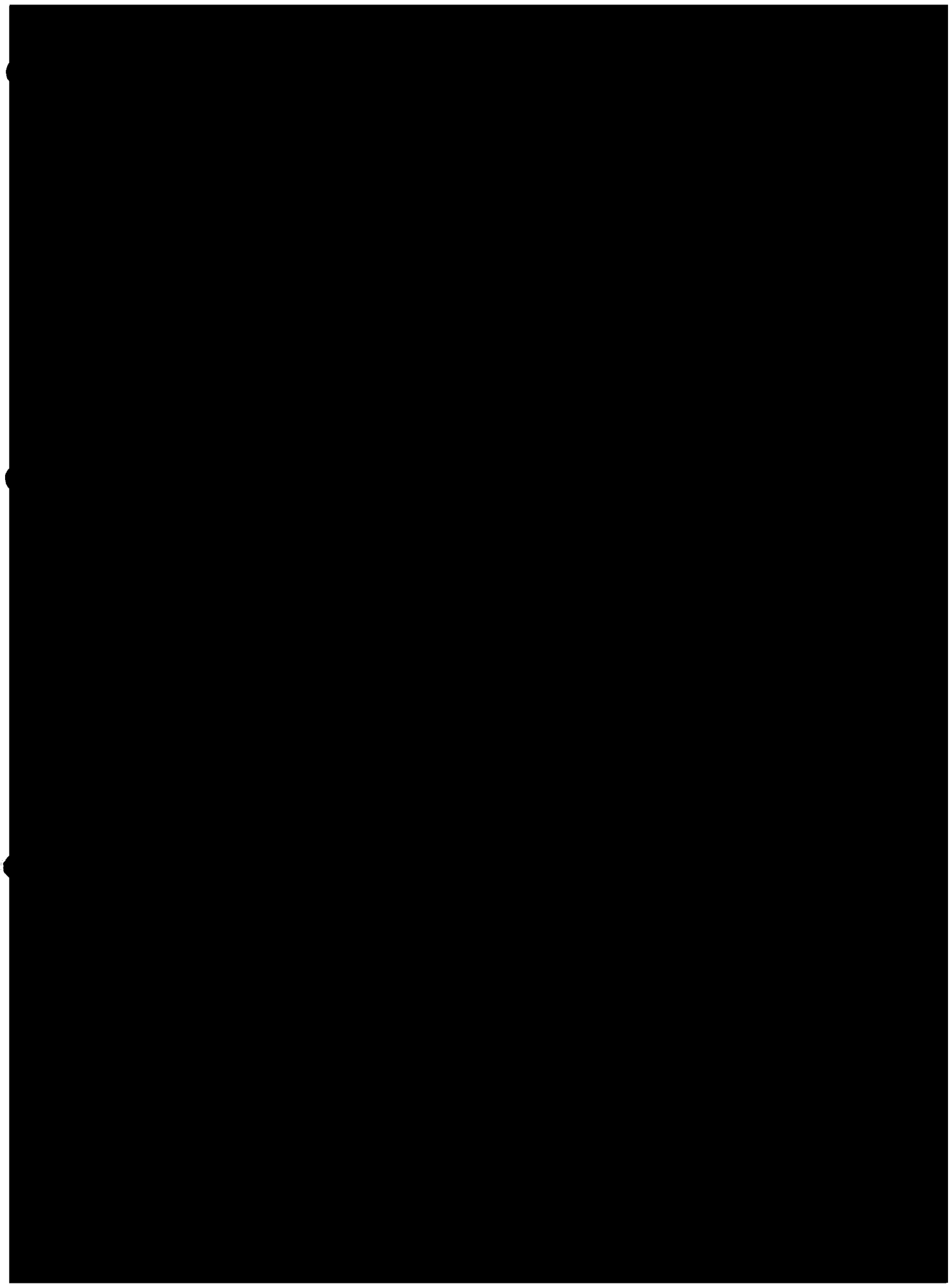
Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org



Please quote our reference when communicating with us about this matter

Our ref: ISPB/sls/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
17 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: 0207-915-7406

Dear Mr Elliott

Dr Jane Barton

I write with reference to our telephone conversation yesterday evening, when you kindly advised me that the application for adjournment of Dr Barton's case at the Interim Orders Committee has been rejected by the Chairman.

I feel obliged to express concern at the position which now results. It seems that either Dr Barton will not attend the hearing, or that she will attend when not medically fit to do so. In either case, Dr Barton's right to a fair hearing appears to be compromised.

I understand, though of course I appreciate you have not had an opportunity to provide with the written reasons for the decision, that there is concern this hearing should take place as soon as possible in terms of the public interest.

I assume that concern is based upon the understanding that the five cases considered by the Police have now been referred to the Crown Prosecution Service. Previously only the case of Gladys Richards had been the subject of referral. It appears the Council attaches some significance to this.

It may assist if I explain that following the decision of the Police to take no further action, not even considering it necessary to refer the cases of Mr Wilson, Mrs Page, Mr Cunningham and Mrs Wilkie to the CPS, relatives of the patients expressed concern at this decision. The Police therefore decided that in all fairness to the relatives the cases should be passed to the CPS for consideration. In fact, the Police have no new information or evidence available to them and indeed have no further concerns. Accordingly, the decision to refer these matters to the CPS is not in reality any significant development in this case.

Yours sincerely

Code A

E:\COMMITTEE\ADAMIOCLETTERS\2002\SEPTEMBER\BARTON-ADJOURN

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

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

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

By fax and Post 020 7202 1663

17 September 2002

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

Dear Mr Barker

Dr Jane Barton

I write in response to your letter and fax dated 16 September 2002, in which you request an adjournment of the Interim Orders Committee (IOC) hearing scheduled to take place on 19 September 2002.

Your application has been placed before the Chairman of the IOC and I confirm that the Chairman has not acceded to your application. The Chairman did note that Dr Barton is currently unwell and appreciates that Dr Barton may not be able to attend the hearing. However, due to the nature of the serious allegations raised the Chairman considers that it is necessary in the public interest that the case be heard as soon as possible.

The Interim Orders Committee will therefore consider the case of Dr Barton at 11:30 on 19 September 2002 at the Council's offices, which are located at 44 Hallam Street, London W1. You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider Dr Barton's case. Your observations should be marked for the attention of Adam Elliott, Committee Section (fax no Code A). You are further invited to state in writing whether you propose to attend the meeting, and/or instruct Counsel.

It is of course open to you to make a further application to adjourn the consideration of Dr Barton's case in writing prior to the hearing of the case by the IOC and/or at the outset of the hearing on 19 September 2002. Please would you write to acknowledge receipt of this letter quoting the reference above.

Yours sincerely

Code A

Adam Elliott
Interims Order Committee Secretariat

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

[redacted]

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
16 September 2002

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

Also by fax: Code A

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Freephone: 0800
Telephone: 020 7202 1500
Fax: 020 7202 1663

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

Dear Mr Elliott

Dr Jane Barton

I write with reference to our telephone conversation on Friday concerning the forthcoming appearance of Dr Barton at the Interim Orders Committee. [redacted] It would not therefore be possible for her to appear at the hearing on the 19th September. In these circumstances I write now to request that this hearing is adjourned to a time when Dr Barton can attend.

[redacted]

[redacted]

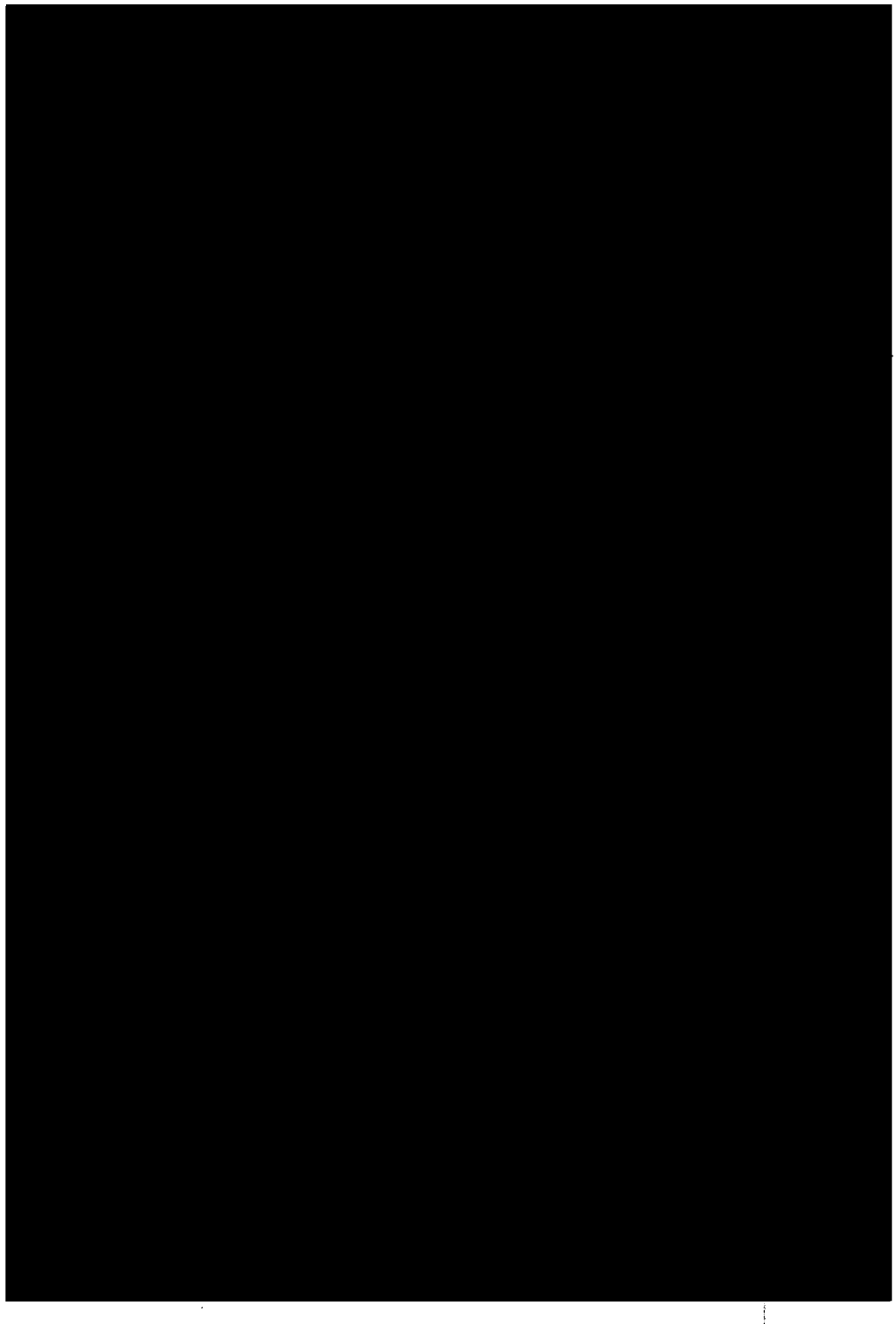
[redacted]

Our ref: ISPB/TOC/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
16 September 2002

I look forward to hearing from you and please do not hesitate to contact me if I can assist further.

Yours sincerely

Code A



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In reply please quote ACE/JJC/VC/FPD/2000/2047

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

23 September 2002

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Mr Peter Bingham
Chairman
Practitioner and Patient Services Agency
Coltbury House
Aldermaston Road
Basingstoke
RG24 9NZ

Dear Mr Bingham

Dr Jane Barton
GMC Registration No: 1587920

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting on 19 September 2002.

Dr Barton attended the meeting, and was legally represented.

After considering submissions from Counsel instructed by the GMC and also from Dr Barton's legal representatives, the IOC considered that it was not necessary for the protection of the members of the public, in the public interest or in Dr Barton's own interests to make an order affecting her registration.

Yours sincerely

Code A

Adam Elliott
Committee Section

Code A

E:\COMMITTEE\IOC\FOLLOWUP\SEPTEMBER\2002\BARTON-HA

In reply please quote ACE/JJC/VC/2000/2047

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

23 September 2002

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Gareth Cruddace
Chief Executive
Hampshire & Isle of Wight Health Authority
Health Authority Head Quarters
Oakley Road
Southampton
SO16 4GX

Dear Mr Cruddace

Dr Jane Barton
GMC Registration No: 1687920

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting on 19 September 2002.

Dr Barton attended the meeting, and was legally represented.

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Yours sincerely

Code A

Adam Elliott
Committee Section

Code A

In reply please quote ACE/JJC/VC/FPD/2000/2047

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

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

23 September 2002

Dr P Old
Acting Chief Executive
Isle of Wight, Portsmouth & SE Hampshire HA
Pinchdean House
Milton Road
Portsmouth PO3 6DP

Dear Dr Old

Dr Jane Ann Barton, **Code A**
Registration No: 1587920

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting 19 September 2002.

Dr Barton attended the meeting, and was legally represented.

After considering submissions from Counsel instructed by the GMC, and also from Dr Barton's legal representatives, the IOC considered that it was not necessary for the protection of members of the public and in the public interests or in Dr Barton's own interests to make an order affecting her registration.

Yours sincerely

Code A

Adam Elliott
Committee Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

LETTER FOLLOWING 19/20 SEPTEMBER BARTON POLICE

In reply please quote ACE/JJC/VC/FPD/2000/2047

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

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

23 September 2002

Detective Superintendent J James
Hampshire Constabulary
Major Incident Complex Police Station
Kingston Complex
Portsmouth
Hampshire PO2 8BU

Dear DS James

Dr Jane Ann Barton Code A
Registration No: 1587920

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting 19 September 2002.

Dr Barton attended the meeting, and was legally represented.

After considering submissions from Counsel instructed by the GMC, and also from Dr Barton's legal representatives, the IOC considered that it was not necessary for the protection of members of the public and in the public interests or in Dr Barton's own interests to make an order affecting her registration.

Yours sincerely

Code A

Adam Elliott
Committee Section

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Read Out

Dr Barton

IOC 19 September 2002

Dr Barton: The Committee has carefully considered the information before it today and has determined that it is not necessary for the protection of members of the public, in the public interest or in your own interests that an Order under Section 41A of the Medical Act 1983, as amended, should be made in relation to your registration whilst the matters referred to the GMC are resolved.

The view of the Committee is that there is no new material in this case since the previous hearing of the Interim Orders Committee on 21 March 2002. The Committee has reached this determination in the light of this and the legal assessor's advice.

THE MDU

Facsimile

The Medical Defence Union Limited
Legal Department

To:	Mr Adam Elliott
Company:	GMC
Fax no:	Code A
From:	Ian S.P. Barker
Date sent:	16/09/02
Time sent:	
No. of sheets inclusive:	4
Re:	DR J. BARTON

If you do not receive legible copies of all the pages please notify us immediately by telephone or fax.

Please quote our reference when communicating with us about this matter

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16 September 2002

Mr Adam Elliott
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Email: mdu@the-mdu.com
Website www.the-mdu.com

Dear Mr Elliott

Dr Jane Barton

I write with reference to our telephone conversation on Friday concerning the forthcoming appearance of Dr Barton at the Interim Orders Committee. [redacted]

[redacted]

[redacted]

[redacted]

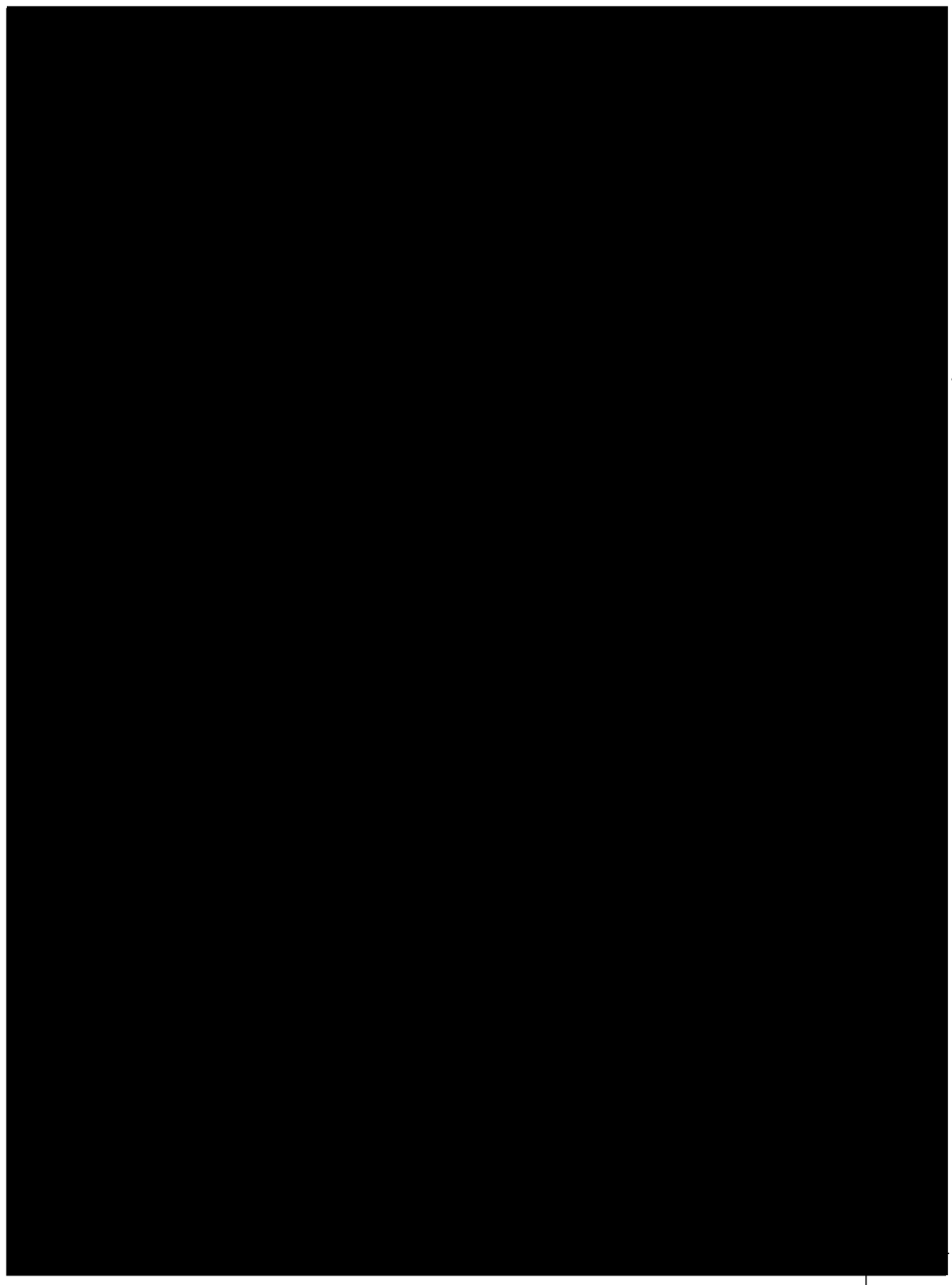
[redacted]

Our ref: ISPB/TOC/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
16 September 2002

I look forward to hearing from you and please do not hesitate to contact me if I can assist further.

Yours sincerely

Code A



GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

In reply please quote VC/MK/2000/2047

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

13 September 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

I am writing to notify you that the information about your conduct received from Hampshire Constabulary and referred by the Preliminary Proceedings Committee on 29 August 2002 for an inquiry by the Professional Conduct Committee, has now been considered by the President of the GMC under Rule 4(a) of the General Medical Council (Interim Orders Committee) (Procedure) Rules 2000.

The information considered by the President is as was considered by the Preliminary Proceedings Committee, a copy of which I enclose. The President was also made aware that the Police and the Crown Prosecution Service are now considering all five cases against you.

The President has noted the powers vested in the General Medical Council by the Medical Act 1983 (Amendment) Order 2000 and the General Medical Council (Interim Orders Committee) (Procedure) Rules 2000 and considers that the circumstances are such that you should be invited to appear before the Interim Orders Committee 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 is in your own interests that an interim order should be made suspending your registration or imposing conditions on your registration in exercise of the powers under section 41A(1) of the Medical Act 1983 as amended.

The President reached his decision having considered the information that the Police and Crown Prosecution Service are now investigating five cases and the fact that the Preliminary Proceedings Committee considered it necessary to refer this case for an inquiry by the Professional Conduct Committee.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

You are invited to appear before the Interim Orders Committee at 11.30 on 19 September 2002 at the Council's offices at 44 Hallam Street, London, W1, 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 Committee 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 (fax no **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 Interim Orders Committee 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.

I enclose copies of the relevant provisions of the Medical Act, the Interim Orders Committee Procedure Rules, and a paper about the procedures of the Interim Orders Committee.

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

Code A

Vanessa Carroll
Assistant Registrar

cc: By Courier
Mr Ian Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ
(your reference: ISP9/TCC/0000070/Legal)

E:\COMMITTEE\IOC\FOLLOWUP\SEPTEMBER\BARTON

In reply please quote ACE/JJC/VC/2000/2047

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

23 September 2002

Special Delivery

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dr Jane Barton

Code A

Dear Dr Barton

Notification of Decision of the Interim Orders Committee

On 19 September 2002 the Interim Orders Committee of the GMC considered whether it was necessary for the protection of members of the public or was otherwise in the public interest or in your own interests to make an Order under Section 41A(1) of the Medical Act 1983 as amended (the Act).

You were present at the meeting, and were represented by Mr Jenkins, Counsel, instructed by the Medical Defence Union.

At the conclusion of the proceedings of the Interim Orders Committee in your case on 19 September 2002 the Chairman announced the Committee's determination as follows:

> "Dr Barton: The Committee has carefully considered the information before it today and has determined that it is not necessary for the protection of members of the public, in the public interest or in your own interests that an Order under Section 41A of the Medical Act 1983, as amended, should be made in relation to your registration whilst the matters referred to the GMC are resolved.
>
> The view of the Committee is that there is no new material in this case since the previous hearing of the Interim Orders Committee on 21 March 2002. The Committee has reached this determination in the light of this and the legal assessor's advice."

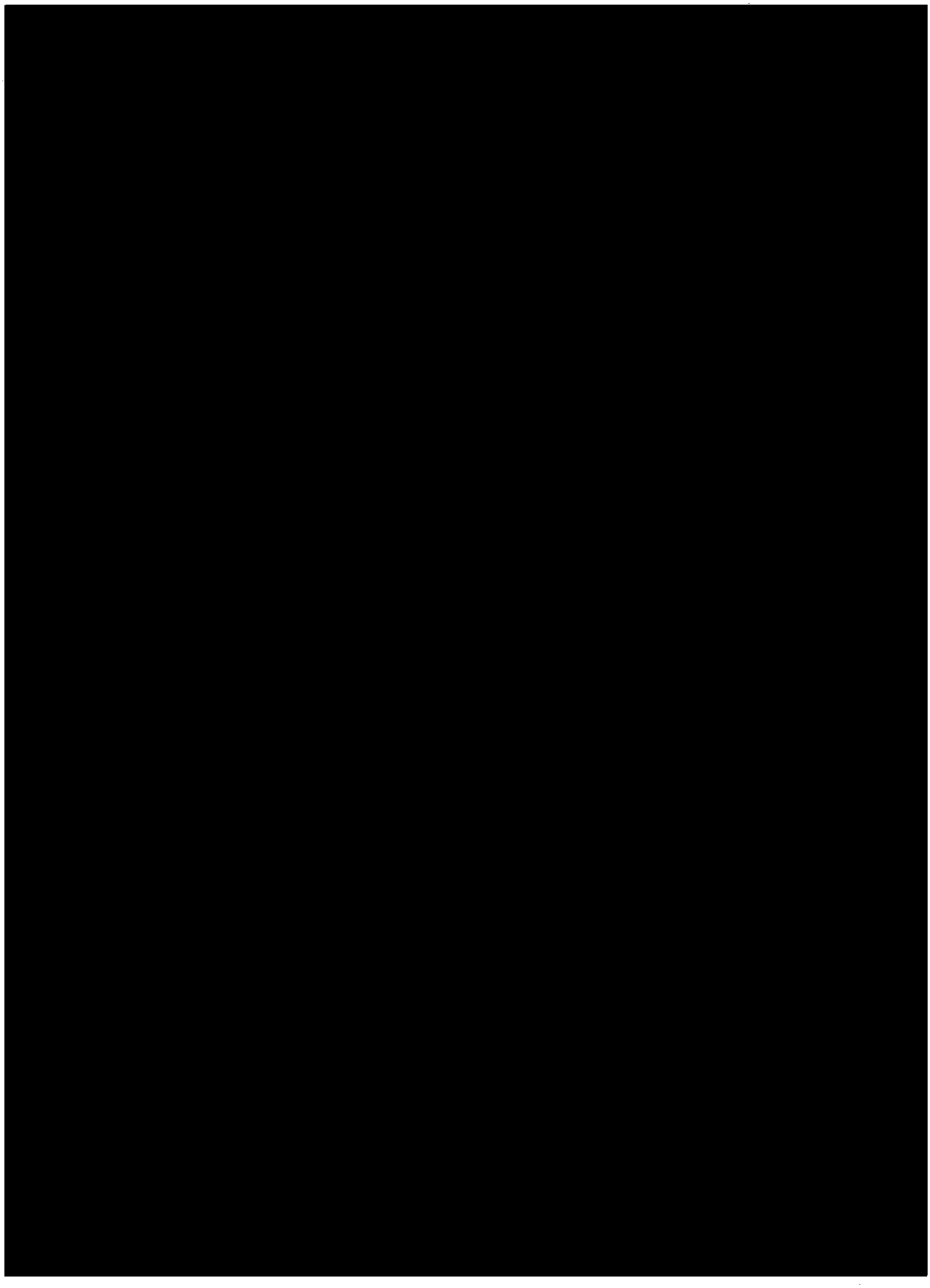
178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3640
email gmc@gmc-uk.org www.gmc-uk.org

Yours sincerely

Code A

Peter Gray
Assistant Registrar

cc: Ian Barker – Medical Defence Union, 230 Blackfriars Road, London SE1 8PJ
[ref: ISPD/815/0005940/legal]



Copy of Memo passed to President 12/9/02.

Memorandum

To **1. Mr Peter Swain**
Acting Head of CCPS
2. President

From **Venessa Carroll**
Senior Caseworker
Conduct Case
Presentation Section
Code A

Date **12 September 2002**

Referral of Case to the Interim Orders Committee: Dr J A Barton

1. The Preliminary Proceedings Committee (PPC) considered this case on 29 August 2002, when the Committee directed that the case be referred to the Professional Conduct Committee (PCC). A copy of the item considered by the PPC is attached (Flag A). Having referred this case to the PCC, the PPC was made aware of the fact that this case had been considered by the IOC and that no Order had been made (see note of discussion, Flag B). The Committee did not therefore make a decision about referral to IOC.

2. At the time of the hearing the Committee was aware that the case of Gladys Richards had been referred back to the CPS. Since that meeting, through contact with the police and the Regional Director of Public Health (SE region), I have been informed that the CPS are now considering all five cases against Dr Barton, not just the case of Gladys Richards as they did previously. In view of this and the fact that the status of the case has changed as it has now been referred to the PCC, you are invited to consider referring this case to the IOC for it to reconsider this case.

3. Please telephone me if you would like to discuss this further. I should be grateful if you could confirm your decision as soon as possible.

TELEPHONE MESSAGE PAD

FROM Venessa Carroll

TO Re: BARTON.

TIME/DATE 12/9/02

GENERAL MEDICAL COUNCIL
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Mike Gill - Regional Director Public Health telephoned re: Dr Barton to inform me that the Police are now submitting 4 further cases to CPS having previously only submitted one case (Gladys Richards) - Police now considering 5 cases. I informed Mike Gill that GMC considering re-referral to IOC & I will keep him informed. Explained info provided in confidence.

Code A

12/9/02.

Mike Gill - Code A

age taken by .....