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Title BRIEFING NOTES BY SIO MEETING GMC 13/1/00

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BRIEFING NOTES: S.I.O.
Meeting with GMC
13.1.2005.

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- GMC to satisfy re matters of professional conduct or performance warranting formal action.
- S.35A Medical Act [illegible].. GMC right to demand disclosure when necessary to carry out statutory regulatory role.
- Woolgar v CC Sussex 2000.. Balance between competing public interests.
- Previous significant disclosure made [illegible] 2002..
- CPS - release of [illegible] 3 material before criminal [illegible] could amount to an abuse of process.

HAMPSHIRE CONSTABULARY

Code A

OPERATION ROCHESTER.

21.3.02. IOC

Issue. Disclosure of Material to the General Medical Council.

- 12.9.02.. GMC P.P. Committee decide [illegible], to be heard by [illegible] Committee.

Situation Report.
7th January 2005.

19.9.02. IOC.
10.9.04. [illegible]..
7.10.04. IOC
16.12.04 [illegible]..

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

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

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

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

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

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

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

Esa PAGE Died 3.3.1998. (2) n/c.
Brian CUNNINGHAM Died 26.9.1998. (3)
Robert WILSON Died 18.10.1998. (3)
Alice WILKIE Died 21.8.1998. (2)
Gladys RICHARDS.. 21.8.98. 2/3

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

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

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

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

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

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

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

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

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

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

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

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

General Medical Council Disclosure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Disclosure Options for consideration Friday 23rd July 2004.

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

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

NB.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

David WILLIAMS
Det Supt 7227.
7th January 2005.

Dr Barton -

- Commenced post Clinical Asst to Geriatrician 1988. (additional to G.P. Role)
- 20hrs a week with 24hr day cover. GP experienced & working autonomously..
- Consultants Dr Lord. Tandy although Consultant Cover limited in 1990 - 1999 Dr Tandy's absence.
- Comments that due to her workload that note keeping & records suffered..
- Dr Barton felt obliged to adopt policy of pro-active prescribing outside authority to give nurses a degree of discretion to administer within a range of medications..
- Dr Barton comments that prescriptions were reviewed on a regular basis by Consultants when carrying out their ward rounds..
- Dr Barton's workload increased due to increasing bed occupancy - patients dependency.. As a result increasing time pressures & corners were cut..
- "She was clearly failed in the duties of the post particularly note taking & providing 24hr medical care.

- Elsie Devine..

Diagnosis of Myeloma
- Chronic Renal Failure
- Morphine Sub [illegible] } other than a range of other
- Fentanyl patch. } appropriate Analgesia.. for severe intractable cancer pain..
- B relieve distress Anxiety - agitation..
- Strong opioids to 'enable nursing care.. excessive dose).
- lack of clear assessment of worsening conditions.
- Doubt exists whether Renal failure was irreversible terminal event or decline in Renal function could have been stabilised or reversed.
- Diamorphine - Midazolam given - died 2 days later..

① Diagnosis of Multiple Myeloma clarify with Haematologist

② Renal failure - Renal physician..