Agenda Item 20

Enclosure 17

Health and Care Professions Council
06 December 2018

The Report of the Gosport Independent Panel

For discussion

From Katherine Timms, Head of Policy and Standards

Council, 6 December 2018

The Report of the Gosport Independent Panel – The Right Reverend James Jones KBE

Executive summary and recommendations

Introduction

The Gosport Independent Panel were commissioned to investigate long term, inappropriate administration of opioid drugs at Gosport War Memorial Hospital between 1989 and 2000. The Panel's report ('the Report), published in June 2018, 'found evidence of opioid use without clinical indication in 456 patients' and revealed:

- a 'disregard for human life and a culture of shortening the lives of a large number of patients…';
- an 'institutionalised regime of prescribing and administering dangerous doses of a hazardous combination of medication not clinically indicated of justified, with patients and relatives powerless in their relationship with professional staff.';
- an insufficient and inappropriate response to complaints about patient safety, both at an individual and institutional level; and
- failures by the hospital's senior management, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the CPS, the GMC and the NMC, to protect patients and relatives.

The Government's response to the Report, published in November 2018 states that:

> 'In addition to the actions and commitments set out in this document, it is vital that all organisations and individuals involved in the health and care system continue to reflect on the events described by the report, and do all they can do avoid such a deep failure to occur again.

It also outlined:

> 'The Government recognises that the current framework for the regulation of healthcare professionals is prescriptive, inconsistent and bureaucratic and does not support the development of a modern, flexible workforce. Officials are analysing the responses and the Government will be setting out its proposals to take this work forward shortly.'

Whilst the Report focuses on medical professionals, nurses and pharmacists, the issues raised relate to all healthcare professionals. We therefore felt it was important to review

the Report in its entirety to ensure we are aware of all the relevant implications for our registrants, and are taking appropriate action where required.

Set out below is a discussion on the key issues which relate to the work of the HCPC and its registrants. In taking forward developments in these areas we will work closely with other professional and systems regulators across the UK to ensure information is shared in a timely and appropriate way; reducing risk to the public.

1. *Organisations must listen carefully to the concerns of patients, relatives, and staff, and support them in raising those concerns.*

The vast majority of concerns raised are done so through our fitness to practise function, by registrants, employers, members of the public and other stakeholders.

The FTP improvement plan, which commenced in 2018, has progressed a number of actions which increase our effectiveness in assessing concerns, namely by:

- reviewing the standard of acceptance and developing a new threshold policy with clear guidance and training for employees;

- developing further clarity on our approach to the identification and investigation of health allegations; and

- developing further guidance and training around risk assessments.

As part of our proposed work around professionalism and prevention, we also intend to involve service users more effectively to ensure our regulatory standards and processes are patient centered and relevant.

2. *The duty of candour is vital to protecting patients*

HCPC's Standards of conduct, performance and ethics (SCPEs) require our registrants to be open and honest when things go wrong and deal appropriately with concerns and complaints (standard 8). Furthermore, registrants must report concerns about safety and follow up these concerns where necessary (standard 7).

Standard 8 was included as part of our most recent review of the SCPEs in 2016. Following publication of this new standard, we undertook a programme of communication and engagement work to raise awareness, and have continued to reinforce awareness at stakeholder events.

In addition, we have recently consulted on our revised Indicative sanctions policy, the content of which strengthens our position on the importance of apologies.

3. *Informed consent is necessary for safe and effective care*

The SCPEs require registrants to ‘make sure that [they] have consent from service users or other appropriate authority before [they] provide care, treatment or other services’ (1.4).

We provide guidance on consent in our guidance on confidentiality. We consulted on changes to this guidance in 2017 and made amendments to:

- clarify the definition of ‘consent’ by a service user to the use or disclosure of confidential information – in that it must be voluntary, informed and given by an individual with the capacity to make the decision;
- provide additional guidance on issues relating to capacity;
- expand our guidance on consent issues relating to children and young people; and
- outline the factors the Mental Capacity Act 2005 directs must be considered when determining best interests.

4. Professionals must adhere to governance arrangements for the use of controlled drugs

Registrants that are qualified and annotated prescribers are required to ‘understand the legal context relevant to supplementary and independent prescribing, including controlled drugs, mixing of medicines, off-label prescribing of medicines and the prescribing of unlicensed medicines’ (1.2, Standards for prescribing). All registrants must ‘keep up to date with and follow the law, our guidance and other requirements relevant to [their] practice (3.4, SCPEs)’. As part of this, we would expect registrants to know and observe national and local guidelines on clinical issues including the supply, administration and management of controlled drugs.

The allied health professions differ from other non-medical prescribers because not all those that may become independent prescribers can prescribe controlled drugs. Those professions that can may prescribe from a limited list, and their rights vary across the UK. All registrants must keep within their scope of practice, including in the supply and administration and prescribing of medicines. We have developed more detailed information about this which will launch on the new HCPC website. This content has been reviewed by the MHRA and NHS England.

We are also consulting on adopting the Royal Pharmaceutical Society (RPS) prescribing competency framework. The RPS are currently developing guidance on the safe and secure handling of medicines, which will include controlled drugs. The NMC plan to adopt this guidance in place of their current Standards for medicines management. Should we adopt the RPS framework, we will consider also signposting to the safe and secure handling of medicines guidance.

In December we will issue information in ‘Education Update’ on the rights of each of our professions in relation to the supply, administration and prescribing of controlled drugs to reinforce this knowledge in our prescribing programme leads. We will also consider a blog piece for a registrant audience in Q1 2019-20.

5. Reflection and learning is vital to ensure safe and effective care

Continuing professional development (CPD) is important to keep registrant skills and knowledge up to date so they are able to practise safely and effectively. Registrants are subject to CPD standards which require them to:

- maintain a continuous, up-to-date and accurate record of their CPD actitivies;
- demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
- seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
- seek to ensure that their CPD benefits the service user; and
- upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the Standards for CPD.

Reflection is a fundamental part of CPD and we are currently working with the other health and care regulators to establish a joint statement on reflective practice for registrants.

Decision

The Council is invited to discuss the content of the report at Appendix A and the relevant work being undertaken by the HCPC in this regard.

Background information

- A copy of the report of the Gosport Independent Panel can be found at Appendix A
- A copy of the Government response to the report of the Gosport Independent Panel can be found at Appendix B

Resource implications

There are currently no expected resource implications for this.

Financial implications

There are currently no expected financial implications for this work.

Appendices

- Appendix A: The Report of the Gosport Independent Panel
- Appendix B: The Government response to the report of the Gosport Independent Panel

Date of paper

22 November 2018

Gosport War Memorial Hospital The Report of the Gosport Independent Panel

Gosport War Memorial Hospital
The Report of the Gosport Independent Panel

June 2018

ISBN 978-1-5286-0406-2
CCS0318322076-1

HC1084

Return to an Address of the Honourable
the House of Commons
dated 20 June 2018 for

Gosport War Memorial Hospital: The Report of the Gosport Independent Panel

Ordered by the House of Commons to be printed on 20 June 2018

HC 1084

This publication is available at www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at enquiries@gosportpanel.independent.gov.uk

ISBN: 978-1-5286-0406-2
CCS0318322076-1 06/18

Printed on paper containing 75% recycled fibre content minimum.

Printed in the UK by the APS Group on behalf of the Controller of Her Majesty's Stationery Office.

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When I first came to Gosport and met those who had historical concerns about how their loved ones had been treated in the town's War Memorial Hospital, there were eight families. Once the Independent Panel had been set up, we were soon in touch with over 100 families. The shocking outcome of the Panel's work is that we have now been able to conclude that the lives of over 450 patients were shortened while in the hospital, and to demonstrate that those first families were right to persist in asking questions about how their loved ones had been treated.

Over the many years during which the families have sought answers to their legitimate questions and concerns, they have been repeatedly frustrated by senior figures. In this Report, we seek to understand how and why this has happened. The obfuscation by those in authority has often made the relatives of those who died angry and disillusioned. The Panel itself felt some of that frustration directed towards ourselves at the beginning of our work. The families had already been let down so often that they saw no reason why they should trust a Panel set up by the Government, albeit an independent one.

Some of the family members are the first to acknowledge that their quest for truth and accountability has had an adverse effect on their own lives. They know that the frustration and anger that they feel has sometimes consumed them. This in turn has no doubt made those in authority less inclined to build a bridge towards them and to investigate their concerns thoroughly. But what has to be recognised by those who head up our public institutions is how difficult it is for ordinary people to challenge the closing of ranks of those who hold power.

It is a lonely place, seeking answers to questions that others wish you were not asking. That loneliness is heightened when you're made to feel even by those close to you that it's time to get over it and to move on. But it is impossible to move on if you feel that you have let down someone you love, and that you might have done more to protect them from the way they died. Many of the families to whom the Panel has listened feel a measure of guilt, albeit misplaced.

The anger is also fuelled by a sense of betrayal. Handing over a loved one to a hospital, to doctors and nurses, is an act of trust and you take for granted that they will always do that which is best for the one you love. It represents a major crisis when you begin to doubt that the treatment they are being given is in their best interests. It further shatters your confidence when you summon up the courage to complain and then sense that you are being treated as some sort of 'troublemaker'.

Many of the family members from Gosport have a background in the services. They were brought up to believe that those in authority are there to serve and to protect the community. The relatives did not find it easy to question those in senior positions. It says something about the scale of the problem that, in the end, in spite of the culture of respecting authority, the families, as it were, broke ranks and challenged what they were being told about how their loved ones were treated and how they died.

This Report is a vindication of their tenacious refusal to be dismissed. It shows how they were failed by the professional bodies and by others in authority charged with responsibility for regulating the practice of professionals in the interests of patient safety.

The documents that the Panel has found reveal that, as demonstrated in Table 1 at the end of the Report, during a certain period at Gosport War Memorial Hospital, there was a disregard for human life and a culture of shortening the lives of a large number of patients by prescribing and administering "dangerous doses" of a hazardous combination of medication not clinically indicated or justified. They show too that, whereas a large number of patients and their relatives understood that their admission to the hospital was for either rehabilitation or respite care, they were, in effect, put on a terminal care pathway. They show that, when relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions. These included the senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council and the Nursing and Midwifery Council. All failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.

In the relationship with these powerful public bodies, the families have felt powerless. The Panel's Report gives voice to their historical concerns and substantiates them.

The Panel – in submitting the Report to the Secretary of State for Health and Social Care in order for it to be laid before Parliament on Wednesday 20 June 2018 – expects the relevant individuals and authorities from whom documents were sought to address these historical concerns that the families have carried for over 20 years.

The Right Reverend James Jones KBE
Chair, Gosport Independent Panel

June 2018

Part I

What happened at Gosport War Memorial Hospital, unheeded warnings and the deaths that resulted

Chapter 1: Unheeded warnings, the nurses' concerns and their context

The story of the nurses' concerns

1.1 Early in 1991, Anita Tubbritt, a Staff Nurse at Gosport War Memorial Hospital ('the hospital'), rang Keith Murray, the local branch convenor of the Royal College of Nursing (RCN) (HCO004129, p2). Staff Nurse Tubbritt expressed concerns shared by other members of the night staff working at Redclyffe Annexe over the use of diamorphine and syringe drivers. Documents make it clear that concerns had been raised earlier, in 1988 (DOH702113, p8). Redclyffe Annexe was an elderly care ward, part of the hospital, but located around half a mile away. Diamorphine is a semi-synthetic drug, first derived from morphine in 1874 and also known as heroin.

1.2 Mr Murray said that it was his normal practice when approached to arrange a meeting for the staff involved. The meeting was held in February 1991 at the home of Staff Nurse Sylvia Giffin. Five or six members of staff attended, each of whom worked at the Redclyffe Annexe. The nurses said that diamorphine *"was being prescribed without due consideration being given to the use of milder sedatives first"* (HCO004129, p2).

1.3 Mr Murray later described the concerns he had heard from the nurses in these terms: *"you do not need a sledgehammer to crack a walnut"* and he stated that the nurses named Dr Jane Barton, a clinical assistant who attended the annexe daily, and Dr Bob Logan, a consultant geriatrician who visited on certain days (HCO004129, p2).

1.4 Mr Murray said that, as a result of the meeting, he felt that the nurses' concerns were justified. He suggested that they should write to Isobel Evans, the Patient Care Manager at the hospital (HCO004129, p3). On 15 February 1991, Mr Murray wrote to Staff Nurse Giffin, providing a draft letter (TLE000128, p3). From the start, Mr Murray was concerned that the nurses would be worried about *"repercussions"* they might face as a result of raising their concerns. So in his letter to Staff Nurse Giffin, he reassured her that she could not be disciplined or have any action taken against her for taking this action (p2).

1.5 Mrs Evans replied on 28 February 1991. She suggested a meeting *"so that a plan of action can be determined, if necessary"* (TLE000128, p4). In response, Staff Nurse Giffin agreed to see Mrs Evans and reminded her that she had asked to be accompanied by an RCN representative (p5).

1.6 Mr Murray represented Staff Nurse Giffin at the meeting, which took place on 26 April 1991. It appears from the documents that no one other than Mrs Evans, Staff Nurse Giffin and Mr Murray attended. Mr Murray later recalled that it had been decided that a notice should be displayed within Redclyffe Annexe, stating that the RCN was now aware of the concerns and that *"a meeting would be arranged where staff could attend and voice any concerns without fear of reprisals by disciplinary action"* (HCO004129, p4). He added that a written policy would also be agreed on the use of syringe drivers and controlled drugs (TLE000128, pp8–10).

1.7 Four days after the meeting, Mr Murray wrote to Mrs Evans and provided an open letter designed to encourage staff to talk freely at the proposed staff meeting. In the open letter, he said that he fully supported the decision to hold a meeting with staff and to agree a written policy and said that *"Mrs Evans has every wish to resolve this situation"*. At the same time, in his covering letter, Mr Murray noted that *"it appeared during our meeting that the issue of the syringe drivers had 'upset' Dr Barton"*. He asked if Mrs Evans could convey his apologies to Dr Barton, adding that her clinical judgements had not been questioned. He said that Mrs Evans had described Dr Barton as *"a very caring G.P."* and that *"I equally know and reinforce your views"*. He said that his letter could be shown to Dr Barton (DOH700073, pp9–10).

1.8 The proposed staff meeting was held at Redclyffe Annexe on 11 July 1991. As well as Mrs Evans, ten nurses attended: Sister Iris Goldsmith, Sister Gillian Hamblin, seven staff nurses including Nurse Giffin and Nurse Tubbritt, and Nurse Beverley Turnbull, an enrolled nurse. The note of the meeting, issued by Mrs Evans, records that the following concerns were expressed and discussed (DOH700073, pp11–13):

> "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, each patients 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 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.
>
> 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."

1.9 In response to the concerns raised in the meeting, Mrs Evans asked the nurses to consider a number of detailed points. The general point was made *"that patients suffered distress from other symptoms besides pain but also had the right to a peaceful and dignified death. That the majority of patients had complex problems."* Concluding the meeting, Mrs Evans said that she would invite Kevin Short and Steve King, Nurse Manager for Elderly Services at Queen Alexandra Hospital, to talk to staff and discuss the issues that had been raised (DOH700073, pp12–13).

1.10 In the event, it appears that Mr King spoke to staff, along with Dr Logan, on drug control of symptoms on 20 August 1991 (CQC100068). No record of that meeting is available to the Panel.

1.11 Staff Nurse Tubbritt attended a course on elderly care at the Queen Alexandra Hospital in Cosham, Portsmouth (HCO002551, p3). She later stated that her main concern at the time was that the staff responsible for setting up and administering syringe drivers had not been trained properly. She went on to say that she chose the *"use and abuse of the syringe driver"* as her topic, when asked to prepare a class discussion on something that bothered her at work (HCO004127, p3).

1.12 Her course tutor Gerardine Whitney, Community Tutor for Continuing Education, visited Redclyffe Annexe on 31 October 1991 at Staff Nurse Tubbritt's request. Gerardine Whitney's report of the meeting records the concerns of the nurses with specific examples of patients being prescribed diamorphine via syringe driver with no obvious signs of pain. Gerardine Whitney concluded her report by stating that the staff were concerned that diamorphine was being used indiscriminately, despite having reported their concerns to Mrs Evans, their manager, on 11 July 1991. The staff were also concerned that non-opioids or weak opioids were not being considered prior to the use of diamorphine (DOH600103, pp1–7).

1.13 Gerardine Whitney circulated her report to those who attended the meeting, but also sent it to Mrs Evans, to William (Bill) Hooper, General Manager for the hospital, and to Susan Frost, Principal of the Solent School of Health Studies at Queen Alexandra Hospital. Staff Nurse Tubbritt also wrote to Mrs Evans. Mrs Evans' reply reveals a sharp shift in tone towards the nurses, from apparently open and interested, to critical and patronising. In stating *"once more"* that she would welcome open discussion, she refers to *"disruptive criticism which achieves nothing positive and leaves staff feeling frustrated"* (FAM103794, p13).

1.14 On 7 November, within a week of Gerardine Whitney's visit, Mrs Evans wrote to every trained member of staff at Redclyffe Annexe, and copied her letter to the Night Sister, to Dr Logan, Dr Barton and Mr Hooper. In her letter, she referred to the staff concerns as *"allegations"* and asked for the names of any patients where they believe diamorphine, or any other drug, had been prescribed inappropriately and requested replies *"even if it is purely to state they have no concerns"* (DOH000004, p19).

1.15 Staff Nurse Giffin sent Mrs Evans' letter of 7 November and Gerardine Whitney's report to Mr Murray (FAM001847, p1). Mr Murray wrote to Mrs Evans on 14 November, stating that the earlier agreement for a written policy governing the use of syringe drivers and controlled drugs had not been met. He went on to say that he was *"appalled that the term 'concern' has now been changed to 'allegation'"* and that these were now required in writing (RCN000006, p1). Mr Murray wrote at the same time to Staff Nurse Giffin, saying that, unless he heard from Mrs Evans in a positive way, he would advise that the only way of resolving the issue was to use the grievance procedure. Before doing so, he suggested a meeting with the staff concerned so that he could assure them of the RCN's support. He also said how much he admired the staff involved *"for standing up for your patients in the way that you are"* (DOH700073, p18).

1.16 Mr Murray escalated the issue by writing on 2 December to Chris West, the District General Manager at the Portsmouth and South East Hampshire Health Authority. He asked for advice and revealed that the concerns of the nurses had been dismissed as *"only a small group of night staff who are 'making waves'"* (DOH700073, pp20–1).

1.17 On 5 December, Mrs Evans sent a short memorandum to all trained staff stating that, in the absence of responses to her letter of 7 November, a meeting had been arranged for all staff members concerned about the prescribing of diamorphine. She encouraged staff to attend and said that it was not the intention to make this meeting in any way threatening to staff (DOH700073, p22).

1.18 In a letter of 10 December, Mr Murray queried the purpose of the proposed meeting as *"doubtful"*, given that the concerns of the staff had been discussed earlier in the year and an agreement reached to draw up a written policy. He concluded by referring again to raising a grievance on behalf of the staff if such a policy was not to be drawn up (DOH700073, p23). At the same time, Mr Murray wrote to Staff Nurse Tubbritt, Staff Nurse Giffin and Nurse Turnbull, suggesting that the important thing to remember was that *"you were the ones acting professionally and correctly, try to be assertive and don't be fobbed off"* (DOH700073, p27).

1.19 The staff meeting went ahead on 17 December. Four staff nurses, including Staff Nurse Giffin and Staff Nurse Tubbritt, and two enrolled nurses including Nurse Turnbull, attended. Sister Hamblin also attended. So too did Mrs Evans, Dr Logan and Dr Barton. The note of the meeting shows that discussion was led by Mrs Evans. She said that the 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"* (HCO005892, p1).

1.20 The nurses were cautioned to keep their comments as objective as possible, and it is clear from the note that the discussion was more limited and constrained than the discussion on 11 July or during the visit by Gerardine Whitney on 31 October. The note of the 17 December meeting emphasises that *"all staff had a great respect for Dr Barton and did not question her professional judgement"* (HCO005892, p3). The nurses present were clearly given the impression that, because they were the night staff, they were not seeing the whole picture of each patient's condition. The nurses' concern was interpreted as reflecting a lack of communication with the day staff. It was put to the nurses that, if they had concerns in future, they should approach Dr Barton or Sister Hamblin. If still concerned, they should speak to Dr Logan. The note therefore clearly shows that the nurses were told to keep any concerns within the ward rather than taking their concerns to others outside the hospital.

1.21 After Dr Logan, Dr Barton and Sister Hamblin left the meeting, Mrs Evans asked the remaining nurses if there was any need for such a policy (as in paragraph 1.18). The note says that no one present felt that this was appropriate. Mrs Evans went on to say that 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"* (HCO005892, p3).

1.22 It appears that the meeting on 17 December had the effect of silencing the nurses' concerns, as well as closing down the question of the written policy.

1.23 It is apparent from a letter sent to Staff Nurse Tubbritt and Nurse Turnbull by Mr Murray on 11 January 1992 that Mr West had *"passed the situation onto"* Max Millett, who was then the Unit General Manager. The same letter records that Tony Horne, General Manager for the Community Unit, had been made aware of the concerns and had spoken to Mr Hooper. Mr Murray concludes his letter by suggesting that the meeting on 17 December may have alleviated the nurses' concerns but also states that he felt that the underlying problem was still there (DOH000004, pp3–4).

1.24 This chapter has shown that, following concerns first raised by Staff Nurse Tubbritt working in Redclyffe Annexe, Staff Nurse Giffin wrote to Mrs Evans, the Patient Services Manager, in February 1991 expressing concern over the prescribing and administration of drugs with syringe drivers. The documents reviewed by the Panel show that, between that date and January 1992, a number of nurses raised concerns about the prescribing of drugs, in particular diamorphine. In so doing, the nurses involved, supported by their Royal College of Nursing branch convenor, gave the hospital the opportunity to rectify the practice. In choosing not to do so, the opportunity was lost, deaths resulted and, 22 years later, it became necessary to establish this Panel in order to discover the truth of what happened.

1.25 The documents therefore tell a story of missed opportunity and unheeded warnings. The rest of this chapter provides some background to the hospital and the context in which events unfolded.

Gosport War Memorial Hospital: background and context

Background to the hospital

1.26 Some explanation of the hospital, its background and the contemporary context will help with an understanding of the documents and the story they tell.

1.27 In many respects, developments in the NHS across the country affected Gosport War Memorial Hospital, as they did very many other hospitals. Chapters 2 and 3 explain the national framework for the prescribing and administration of opioids and other drugs, and for clinical, including nursing, standards. While that national context is paramount in understanding the events at the hospital, other factors are also important. In particular, it helps to understand the relevant geography and history of the town of Gosport and the hospital.

1.28 Geographically, Gosport occupies a very distinct location on a peninsula in Hampshire, on the western side of Portsmouth Harbour, opposite the city of Portsmouth. By water, Gosport and Portsmouth are only separated by several hundred yards, and the journey by ferry takes less than ten minutes. The ferry service is described as one of the longest-serving in the UK. Given the extent of Portsmouth Harbour, however, the separation by road is greater, at nearly 15 miles, and the journey takes around half an hour. Gosport is about 83 miles from London, and the journey takes two hours or more by road or rail.

1.29 Gosport's geography has shaped its history, particularly in terms of its military significance and its hospitals. The origins of Gosport appear to lie in the village of Alverstoke, a little over a mile away, but the village still retains a separate sense of identity from Gosport town centre. During the Civil War in the 17th century, Gosport supported parliament while Portsmouth supported the king. Portsmouth was the place where the dockyards were built (dating back to the late 15th century), while Gosport provided their storehouses, timber yards and other supplies.

1.30 The link between Gosport's military and its hospitals is of very long standing. The Royal Naval Hospital at Haslar opened in Gosport in 1753, initially as a hospital for sick and injured sailors. Much more recently, Gosport War Memorial Hospital opened in 1923, and it is the only remaining hospital situated within Gosport itself, since the closure of Royal Hospital Haslar in 2009. There were (and still are) other hospitals in the wider Hampshire area at which the people of Gosport have been treated, including St Mary's General Hospital and Queen Alexandra Hospital in Portsmouth.

1.31 Gosport's pride in its military connections was reflected in the naming of the wards at Gosport War Memorial Hospital, including Ark Royal, Daedalus, Dryad and Sultan. Moreover, the town's war memorial is situated within the grounds and is home to the annual Remembrance Day service.

1.32 The pride of local people and their attachment to their hospital was illustrated by the successful campaign to save Gosport War Memorial Hospital from closure in the 1990s and indeed its redevelopment in 1994.

1.33 Gosport War Memorial Hospital has developed as a community hospital. The Community Hospitals Association explains that community hospitals vary considerably, as they have adapted to the needs of their local populations, and they are highly valued and supported by local people through volunteering, fundraising, promoting and campaigning.

1.34 In 2006, the Department of Health defined a community hospital as a service offering integrated health and social care supported by community-based professionals. The facilities of a community hospital are to be developed through negotiations between local people, practitioners and the NHS, and services offered include rehabilitation, palliative care, intermediate care, surgical care, emergency and maternity.

1.35 In community hospitals, medical care is normally led by GPs in liaison with consultants, nursing and other health professionals as required.

1.36 Gosport War Memorial Hospital is located in Bury Road, Gosport. The hospital also included Redclyffe Annexe, situated in The Avenue, half a mile away in the direction of Alverstoke. Redclyffe Annexe is relevant to events at the hospital as described in the earlier part of this chapter, in the period up to 1994, when the Annexe closed.

1.37 In addition to Redclyffe Annexe, the events in this Report centre on Daedalus, Dryad and Sultan wards at the hospital. A major rebuild of the hospital took place between 1993 and 1994. Services for elderly male and female patients were then provided on Daedalus and Dryad wards. When Redclyffe Annexe closed, the patients and most staff were moved to Dryad Ward. Apart from Daedalus and Dryad wards, the hospital also provided a mental health inpatient unit, a small accident and emergency department and a small maternity unit.

1.38 At the time of the first recorded concern about clinical practice at the hospital in 1991, the hospital was managed by Portsmouth and South East Hampshire Health Authority, as a directly managed unit. Over the period covered by this Report, there were a number of changes to the bodies responsible for running the NHS, including the hospital. Chapter 4 refers to the relevant responsible bodies and explains their significance to the hospital at the time.

Dr Harold Shipman

1.39 In order to understand the context of events as they emerge from the documents reviewed, it may be helpful to recall that the case of Dr Harold Shipman coincided with this period.

1.40 Dr Shipman was a GP from 1974. Throughout his career as a GP, Dr Shipman enjoyed a high level of respect within the communities in which he worked. In Hyde in Greater Manchester, he was extremely popular with his patients, particularly his elderly patients.

1.41 In September 1998, Dr Shipman was arrested, interviewed and charged with the murder of Mrs Kathleen Grundy, and with other offences associated with the forgery of her will, under

which he was to be the sole beneficiary of her estate. He was subsequently suspended from practice and charged with 14 further murders.

1.42 In January 2000, Dr Shipman was convicted of 15 counts of murder and one of forging Mrs Grundy's will. He was sentenced to 15 terms of life imprisonment and, for the forgery, a concurrent term of four years' imprisonment. The trial judge said that his recommendation to the Home Secretary would be that Dr Shipman should spend the remainder of his days in prison.

1.43 The Professional Conduct Committee of the General Medical Council subsequently erased Mr Shipman's name from the medical register.

1.44 Between August 2000 and April 2001, the Coroner for South Manchester conducted inquests into the deaths of 27 patients of Dr Shipman, recording verdicts of unlawful killing in 25 cases and open verdicts in the remaining two. In January 2001, the Secretary of State for Health established the Shipman Inquiry, chaired by Dame Janet Smith DBE. On 18 May 2001, the Coroner opened inquests into a further 232 deaths. The Shipman Inquiry published six reports between July 2002 and January 2005. Mr Shipman died in 2004 by hanging himself in his cell at Wakefield Prison.

Treatment of Graham Pink

1.45 One further point of context concerns Graham Pink, a nurse at Stepping Hill Hospital in Stockport. Nurse Pink worked in wards for elderly patients and complained about the poor standards of care resulting from insufficient staffing from 1989 to 1993 and other concerns, including record keeping.

1.46 Nurse Pink was dismissed from his post as he was accused of breaching patients' confidentiality when his letters of complaint to an MP became public. The circumstances of Nurse Pink's allegations and his sacking attracted publicity, drawing attention to the risk of dismissal for NHS staff who might voice concerns publicly. Nurse Pink was successful at a subsequent industrial tribunal, where Stockport Health Authority sought to justify its position by saying that the defence of patient confidentiality was the golden rule of nursing.

Conclusion: what is added to public understanding

- **Following concerns first raised by Anita Tubbritt, a staff nurse working on Redclyffe Annexe, Sylvia Giffin, a fellow staff nurse, wrote to Isobel Evans, the Patient Care Manager, in February 1991 expressing concern over the prescribing and administration of drugs with syringe drivers.**

- **The documents reviewed by the Panel show that, between that date and January 1992, a number of nurses raised concerns about the prescribing of drugs, in particular diamorphine. In so doing, the nurses involved, supported by their Royal College of Nursing branch convenor, gave the hospital the opportunity to rectify the practice. In choosing not to do so, the opportunity was lost, deaths resulted and, 22 years later, it became necessary to establish this Panel in order to discover the truth of what happened. The documents therefore tell a story of missed opportunity and unheeded warnings.**

- **Gosport's geography has shaped its history, particularly in terms of its military significance and its hospitals. The link between Gosport's military and its hospitals is of very long standing. Gosport's pride in its military connections was reflected in the naming of the wards at Gosport War Memorial Hospital and in holding the annual Remembrance Day service at the hospital. The pride of local people and their attachment to their hospital was illustrated by the successful campaign to save the hospital from closure in the 1990s and indeed its redevelopment in 1994.**

Chapter 2: Prescribing and administration of drugs and the deaths that resulted

Introduction

2.1 The documents show that Staff Nurse Anita Tubbritt, Staff Nurse Sylvia Giffin and Nurse Beverley Turnbull acted to alert authorities at Gosport War Memorial Hospital ('the hospital'). Their concern was the medication – principally diamorphine given by syringe driver – prescribed for and administered to patients in their care.

2.2 The evidence available suggests that some families also voiced concerns about the drugs administered, as well as wider concerns. The Panel has seen references to individual complaints, mainly informal rather than formal. In one case a complaint dates from 1982, while other complaints date from 1989. The lack of documentation in the intervening period has prevented the Panel from assessing the pattern of any complaints made at that time, or the response to those complaints. Of the families who subsequently contacted the Panel, around two-thirds said that their primary concern was indeed the medication; that is, diamorphine injected by syringe driver and a number of other drugs prescribed for and administered to their loved ones.

2.3 The Panel initially examined the case notes for 163 men and women who were patients on Redclyffe Annexe, Mulberry Ward, Sultan Ward, or one of the male or female elderly care wards, and, after 1993, Daedalus and Dryad wards at the hospital. These were patients whose deaths were investigated as part of Hampshire Constabulary's Operation Rochester or whose families came forward to the Panel and asked for their relative to be included in its review. They are the **Initial Group of patients**.

2.4 The Panel was deeply concerned by what it found and therefore extended its analysis to cover a greater number and a wider range of patients who died at the hospital between 1987 and 2001, where the Panel had access to their medical records and death certificates. These are the **Wider Group of patients**.

2.5 This chapter explains the drugs that were prescribed at the hospital, the law that applies and the clinical guidance that should have applied. The chapter goes on to set out the Panel's analysis of the drugs as they were prescribed and administered and sets out eight key 'findings'. By 'findings' the Panel is revealing what has been found in the documents provided.

2.6 The Panel found that, as well as expressing the same primary concern, in many instances the families' recall was striking. Relatives, and sometimes patients themselves, could not understand why powerful painkillers had been given in high doses and then escalated further, increasing sedation; in some cases, lives were shortened.

2.7 This same theme emerges time and time again from the families' experience. For example, the daughter of one patient discovered that a syringe driver had been inserted. She queried this because she knew her father wasn't in pain and didn't need it, but ward staff were dismissive, telling her she was not a nurse and that they were the professionals. She was furious and called her father's GP, who arranged for the syringe driver to be taken out and for her father to come home.

2.8 Another patient was admitted for respite care but deteriorated and became confused during his stay. Staff asked permission to give him diamorphine but his daughter refused, as he was not in pain. However, her mother later agreed and he was started on diamorphine by syringe driver. He died the same day.

2.9 A man admitted for dementia was started on a diamorphine syringe driver. Staff asked his son for permission and he gave it but felt there was no explanation of what it meant to be given diamorphine. The dose was doubled and his father died five days later. His son felt that the diamorphine effectively killed him.

2.10 These are only three allegations from the families who have been in touch with the Panel. There are many more. For example, some families told us of their concerns that medications they believed to be essential had been discontinued during their relative's stay at the hospital. Powerful though these stories are, the Panel has looked beyond them at the detail of the cases. The skilled, safe and effective use of powerful analgesics and other sedative drugs can have an enormous positive impact on patients' comfort and well-being. But, used wrongly, they can also cause great harm. In other words, the medication prescribed at the hospital would have been appropriate where that medication in the dosage prescribed and administered was justified by the patient's condition; that is to say where it was 'clinically indicated'. In order to understand what the documents reveal about the prescribing and administering of drugs that were not clinically indicated, it may be helpful to explain the therapeutics of strong analgesics and related drugs.

2.11 This chapter therefore gives an overview of: the drugs used at the hospital and their benefits, risks and place in therapy; the principles that underlie their safe prescribing; the standards and guidance on prescribing that were extant locally, nationally and internationally; and the governance, prescribing and record-keeping processes that were in place at the hospital at the time. This chapter concludes with the Panel's examination of how these drugs were used at the hospital and the deaths that resulted.

Overview of drugs used at the hospital

2.12 Opioid analgesics are a large group of drugs used to treat moderate to severe pain, most commonly in trauma, myocardial infarction (heart attack) or other acute pain, and palliative care of people with cancer or other end of life conditions. They are also widely used in anaesthetic practice. The terms 'opioid' and 'opiate' are often used interchangeably and this is of no clinical significance.

2.13 Strictly speaking, opiates are the drugs that occur naturally in opium – mainly morphine and codeine – while opioids include a much wider group of synthetic or semi-synthetic drugs such as diamorphine, pethidine, fentanyl and tramadol. They were formerly also known as narcotic analgesics, reflecting their powerful sedative, as well as analgesic, effects. The British National Formulary (BNF), the authoritative national compendium of advice on drug therapy, uses the term opioid, which the Panel has adopted throughout this Report.

2.14 Opium is the dried juice of the seed capsule of the opium poppy. It contains 10–12% morphine and has been used medicinally since prehistoric times. Laudanum was a tincture (alcoholic solution) of opium containing about 1% morphine, which was widely used in the UK for pain and cough and, until the early 20th century, was freely available without prescription.

2.15 Opioids remain central to the management of acute and chronic pain. Whether naturally occurring like morphine, or more recent synthetic or semi-synthetic drugs like diamorphine and fentanyl, they all act in the same way. The newer opioids began to emerge in the 19th century with the development of the modern chemical industry. For example, diamorphine is a semi-synthetic drug first derived from morphine in 1874. It was marketed under the trade name heroin – incredibly in the light of what we now know of its addictive properties – as an over-the-counter, non-addictive analgesic.

2.16 The history of opioid chemistry is in fact one of repeated but doomed attempts to produce a non-addictive strong painkiller. This is exemplified most recently by tramadol, which was initially thought to be safer and less addictive than other opioids when introduced in the UK. However, it is now known to be widely misused and to cause widespread dependency and increasing numbers of deaths through accidental or deliberate overdose. Following a government consultation, it was therefore reclassified as a controlled drug in 2014.[1,2] Pethidine is a totally synthetic drug introduced in 1939 and widely used in obstetrics for many years. Fentanyl, a highly potent synthetic opioid which is also active via the skin so can be used in dermal patches, was discovered in 1960.

2.17 Opioids are of immense value in the management of acute and chronic pain and in anaesthetic practice:

> "Among the remedies which it has pleased almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium."
>
> Thomas Sydenham, physician, 1680

Opioids are used to help manage the acute pain of trauma and myocardial infarction, in maintaining pain control in anaesthesia, and in the management of post-operative pain. Their appropriate and expert use in palliative care can transform patients' comfort and well-being at the end of life.

2.18 All opioids work by acting on specific sites in the central nervous system (receptors) with which the drug combines. Opioid receptors carry pain messages to the brain and the drugs block or reduce the perception of pain. Endorphins – 'the brain's own morphine' – produce their effects in the body by acting on the same receptors, thereby helping to control pain. Because of this very specific action, opioids are also one of the few groups of drugs for which there are specific antidotes (for example, naloxone), which are used to reverse the toxic effects of overdose and poisoning.

2.19 Although they vary in potency and in the range and severity of their side effects, all opioids produce profound analgesia, sedation and euphoria. This combination of effects is particularly valuable in treating traumatic or other acute pain. At higher doses, all opioids depress respiration, and this is their major dose-limiting side effect. Death from opioid overdose is invariably due to respiratory arrest. All opioids produce tolerance; that is to say, with continued use larger doses are needed to achieve the same effect. They can all produce dependency

1 HM Government, 2013. *Consultation on prescription drug tramadol*.
2 HM Government, 2014. *Home Office Circular 008/2014*.

(addiction) with continued use. Their therapeutic value is therefore accompanied by huge potential for harm, either by careless use or deliberate misuse. Massive research efforts have been unable to disaggregate these properties of opioids.

2.20 Opioids have what pharmacologists call a **narrow therapeutic index**. That is, the ratio between a therapeutic dose and a harmful dose is small. For example, in an opioid-naïve person, a single dose of 5–10 milligrams (mg) diamorphine would provide profound pain relief but 30 mg could be lethal. Few drugs exhibit this phenomenon and most have a wider margin of safety. This means that accidental death can occur from relatively low doses if, for example, an inexperienced or over-tired out-of-hours doctor inadvertently overdoses a patient by selecting from the emergency bag a dose of 30 mg or more rather than a 5 or 10 mg ampoule of diamorphine, leading to death from respiratory arrest.[3,4]

2.21 In the criminal sphere, a striking feature of the murders committed by Harold Shipman is that, although he is known to have used much higher doses, he killed many of his victims with no more than a single 30 mg dose of diamorphine. As they were invariably opioid naïve, this was sufficient to cause death by respiratory arrest. In the report of her Inquiry into his crimes, Dame Janet Smith wrote:[5]

> "It is now clear that, during 1993, Shipman was using 30mg ampoules of diamorphine to kill and was replenishing his stock as and when necessary … With the 14 ampoules he obtained between February and August 1993, Shipman killed 13 patients during the same period."

2.22 Paradoxically, while relatively small doses can be lethal in people who are opioid naïve, the development of tolerance means that those taking opioids over a prolonged period – whether for chronic pain or because of addiction – can survive doses that would otherwise be rapidly fatal. It is not uncommon for a person taking long-term morphine to need very large daily doses. The BNF states that following initial dose titration, patients with pain in palliative care may require oral morphine at doses of up to 1,200 mg per 24 hours.[6]

2.23 Getting the dose of opioids right is particularly important in people with severe pain in terminal illness. While large doses are often needed, these increase the risk of respiratory arrest. Safe adjustment of the dose (titration) requires skill and an understanding of the pharmacology of these drugs. The current medico-legal position is that, where it is necessary to control otherwise intolerable pain, appropriate escalation of the dose where there may be a concomitant risk of respiratory arrest is both lawful and ethical. Increasing the dose simply to end life is unlawful. This can present clinicians with difficult decisions, and is the subject of intense debate on assisted dying. This issue is often referred to as the principle of double effect.

2.24 Older people are particularly susceptible to the adverse effects of drugs in general and opioids in particular. As long ago as 1981, Ramsay and Tucker, a consultant physician and clinical pharmacologist respectively, were among the first health professionals to point this out.[7] They wrote:

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3 National Patient Safety Agency, 2006. *Safer practice notice 12: Ensuring safer practice with high dose ampoules of diamorphine and morphine*.

4 Care Quality Commission, 2010. *Investigation into the out-of-hours services provided by Take Care Now. Part 1: The death of Mr David Gray and previous incidents involving overdoses of diamorphine*.

5 HM Government, 2002. *The Shipman Inquiry*. *First report, Volume 1: Death disguised*. http://webarchive.nationalarchives.gov.uk/20090808163951/http://www.the-shipman-inquiry.org.uk/images/firstreport/narrative/pdf/vol1.pdf (accessed 27 November 2017), pp160–1.

6 National Institute for Health and Care Exellence, 2017. *Morphine: indications and dose*. https://bnf.nice.org.uk/drug/morphine.html (accessed 27 November 2017).

7 Ramsay RE and Tucker GT, 1981. Today's treatment: Drugs and the elderly. *British Medical Journal*, 282, pp125–7.

> "The risk of adverse reactions overshadows all other considerations when prescribing for the elderly, although there is some suggestion that general practitioners, who are responsible for the bulk of prescribing, may not be fully aware of this. Elderly patients are more likely than the young to react adversely to drugs prescribed in hospital and they are also more likely to be admitted to hospital or to die because of adverse reactions."

They noted that increased sensitivity to opioids was a *"common or serious cause of adverse reactions in the elderly"* and that doses should therefore be reduced.

2.25 The principle that older people need special care and consideration – especially if they are very old – from prescribers soon became well established. There are two main reasons for this. First, the nervous system of older people is inherently more sensitive to the effects of opioids and also other sedative drugs such as midazolam and hyoscine. Second, the elimination of these drugs by the body – mainly through the kidneys and liver – is often impaired. These factors combine to alter the balance of benefit and harm and can put older people at considerable risk from adverse effects on the nervous system such as confusion, drowsiness and slurred speech, with the serious possibility of respiratory arrest. A degree of renal (kidney) impairment is common in older people and is known to increase and prolong the effects of opioids. In 1984, Regnard and Twycross were the first to report this. They found that, of their palliative care patients receiving morphine, those with renal impairment needed less than half of the average dose given to all their patients when titrating upwards until pain was controlled.[8]

2.26 By 1987, the BNF was therefore cautioning that opioids should be avoided in older people, or used with caution and reduced doses:[9]

> "In general, narcotic analgesics should be used with caution, if at all, in patients with hepatic and renal impairment … dosage should be reduced in elderly and debilitated patients."

2.27 Successive editions of the BNF have continued to carry warnings about the hazards of opioids and other drugs acting on the nervous system in elderly people or those with renal impairment.

Opioids prescribed at the hospital

2.28 A range of opioids was used at the hospital, including morphine in various dosage forms – two oral solutions, one weaker and one more concentrated (oral morphine), and slow-release tablets (modified release morphine) of various strengths. Diamorphine was used both as single injections and, more commonly, by continuous subcutaneous infusion using a syringe driver. Fentanyl was used in the form of skin (transdermal) patches, which were first introduced in the UK in 1994.

2.29 Fentanyl can be very useful in patients who cannot take oral medicines and whose veins or skin are too fragile for intravenous or subcutaneous administration. The drug is absorbed by the skin, is a very effective analgesic, and invasive procedures are avoided. However, use of fentanyl can be problematic.

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8 Regnard FB and Twycross RG, 1984. Metabolism of narcotics. *British Medical Journal*, 288, p860.

9 British Medical Association and Royal Pharmaceutical Society of Great Britain, 1987. Narcotic analgesics. *British National Formulary*, 13, p168.

2.30 Fentanyl is much more potent than morphine or diamorphine: a patch delivering 25 micrograms of fentanyl per hour (600 micrograms per 24 hours) is approximately equivalent to 90 mg of oral morphine over 24 hours, or 30 mg of diamorphine given by syringe driver. It is therefore some 150 times more potent than oral morphine or 50 times more potent than infused diamorphine. The risks of miscalculation or dosing error are obvious. But the huge difference in potency is not a problem provided dosing is accurate and changes to and from fentanyl patches are managed properly.

2.31 Fentanyl patches should therefore be used with great care, particularly in patients who are not known to have previously tolerated strong opioids; that is, people who are opioid naïve. The BNF has warned that it could take 24 hours for the full effects of fentanyl to become evident, and that replacement of fentanyl with other opioids should be initiated at a low dose and increased gradually.[10] A starting dose of 25 micrograms per hour was initially recommended for opioid-naïve patients, but this was recognised to be excessive. In 2008, responding to reports of serious and fatal overdoses of fentanyl patches, the Medicines and Healthcare products Regulatory Agency issued a warning that they should only be used in patients who have previously tolerated opioids.[11] This advice was incorporated in all subsequent editions of the BNF. Because fentanyl is very long acting when given by the transdermal route, the drug can take up to five days to be completely eliminated from the body after a patch is removed. Any replacement opioid must be introduced cautiously at a low dose and increased gradually, with careful monitoring for any adverse effects. In the absence of these precautions, concurrent use of fentanyl patches with other opioids can be fatal.

2.32 The very wide range of opioid dosage forms and strengths can be confusing for professionals, especially those not expert in palliative care. The calculation of equivalent doses and dose intervals when changing patients from one opioid to another or from one dosage form to another needs great care. Both accidental overprescribing and accidental over-administration – which can be lethal – have been the subject of NHS patient safety alerts. In 2008, reviewing 4,223 patient safety incidents involving opioids, the National Patient Safety Agency stated:[12]

> "There are risks if members of the healthcare team who prescribe, dispense or administer opioid medicines have insufficient knowledge of dosage and the requirements of the patient concerned. Every member of the team has responsibility to check that the intended dose is safe for the individual patient."

2.33 Despite the emergence of many newer drugs, morphine remains the drug of choice for many indications, including palliative and post-operative care. The UK is unique in that diamorphine has also been widely used in healthcare. In most other countries, its use is discouraged or unlawful because of its reputation as the street drug heroin. Diamorphine was formerly believed to be particularly effective in relieving severe pain. It is more potent than morphine (about three times stronger) and some forms are more water-soluble and can be formulated into injections with very small volumes, which is useful for subcutaneous infusion. It was for many years therefore the opioid of choice for severe pain, particularly in palliative care.

2.34 The failure in 2004 of the only diamorphine production line in the UK led to the urgent transfer of large numbers of patients to equivalent doses of morphine. This was found to be

10 British Medical Association and Royal Pharmaceutical Society of Great Britain, 1998. Fentanyl. *British National Formulary*, 36, p204.

11 HM Government, 2008. *Serious and fatal overdose of fentanyl patches*. www.gov.uk/drug-safety-update/serious-and-fatal-overdose-of-fentanyl-patches (accessed 5 May 2018).

12 National Patient Safety Agency, 2008. *Rapid Response Report: Reducing dosing errors with opioid medicines*. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59888&q=0 (accessed 28 November 2017).

just as effective and diamorphine never regained its former therapeutic niche. Morphine is now invariably recommended as the opioid of choice in analgesic and palliative care guidelines.

2.35 The main use of opioids is for the relief of severe and intractable pain; they are also used in anaesthetics and post-operative care. Potent opioids such as morphine, diamorphine and fentanyl can eliminate pain or at least render it tolerable and they also have sedative effects. They induce a state of relaxation, tranquillity, detachment and well-being (euphoria) that can be a valuable adjunct to pain control. Occasionally, they can cause an unpleasant reaction (dysphoria) and they frequently cause nausea and vomiting.

2.36 Opioids are not normally used for agitation or confusion in the absence of pain. They are generally unsuitable for terminal agitation, anguish or distress and, if used inappropriately, may cause or exacerbate these problems. In the absence of pain or in excessive doses, they can cause sleep disturbances, hallucinations, sweating and confusion. If a patient needs sedation the BNF recommends haloperidol or other tranquillisers.

Legal control of opioids

2.37 The risk of misuse and dependency means that opioids are tightly regulated in most jurisdictions. In the UK, the Misuse of Drugs Act 1971 and its regulations govern all aspects of their use. Internationally, they are governed by the UN Single Convention on Narcotic Drugs 1961 and its protocols, to which the UK and virtually all UN member states are signatories.

2.38 Strong opioids such as morphine, diamorphine and fentanyl are known as 'class A controlled drugs' under UK legislation. Penalties for their unlawful use or supply can be severe. However, the culture in the British and most western healthcare systems is that, providing legal and professional frameworks are respected, the great therapeutic value of these drugs is recognised and they may be prescribed without undue restriction when they are clinically needed.

2.39 The legal and NHS management frameworks for controlled drugs were tightened significantly following Dame Janet Smith's reports into the crimes of Harold Shipman.[13] Custody, prescribing and record-keeping requirements for controlled drugs in hospitals are discussed below. Most prescribers adopted a more cautious approach to the use of opioids following the trial of Shipman, the Inquiry reports and the changed legal and professional environment. Nevertheless, the UK legal and professional frameworks for clinical use of opioids remain relatively liberal in contrast to some jurisdictions – for example, eastern Europe, where very stringent controls mean that many patients cannot access opioids and are denied essential relief for severe pain which would be routine in this country. In the UK, although theft and diversion of therapeutic opioids does occur, it is generally not a major cause of drug dependency and crime – the murders committed by Shipman being of course a striking exception.

Other psychoactive drugs prescribed at the hospital

2.40 Families' concerns have focused predominantly on the use of opioids, rightly so in the light of their potency and potential for harm. The Panel's analysis of clinical records from the hospital shows that opioids were frequently given to patients in conjunction with other drugs that affect

13 HM Government, 2004. *The Shipman Inquiry. Fourth report: The regulation of controlled drugs in the community*. http://webarchive.nationalarchives.gov.uk/20090808163828/http://www.the-shipman-inquiry.org.uk/4r_page.asp (accessed 28 November 2017).

the central nervous system – mainly midazolam and hyoscine, but also sometimes haloperidol, thioridazine or other sedatives.

2.41 Midazolam is a short-acting anxiolytic or tranquilliser which was frequently given in conjunction with diamorphine to patients at the hospital. It is a member of the benzodiazepine group, the best-known example of which is diazepam (Valium). These drugs act on a different set of specific receptors in the nervous system, which are independent of the opioid receptor system. As with opioids, there is a specific antagonist to benzodiazepines – flumazenil – which is used to treat overdose and poisoning.

2.42 Midazolam is normally given by injection. Its main use is in anaesthetics and to achieve 'conscious sedation', particularly for painful or uncomfortable procedures such as endoscopy or dressing burns. It is often used in combination with a short-acting opioid such as fentanyl to produce profound sedation and analgesia while the patient remains conscious and able to cooperate with the clinician. It has anticonvulsant actions and is used in some forms of epilepsy. It has a place in palliative care (when it is given by continuous subcutaneous infusion) for two specific purposes: to treat seizures, or in patients who are very restless or agitated (sometimes referred to as 'terminal agitation'). Midazolam has no analgesic effects.

2.43 Temazepam is another benzodiazepine, which was sometimes given by mouth as a night sedative to patients at the hospital. Clomethiazole is a non-benzodiazepine, non-opioid sedative for severe insomnia, and also for agitation and restlessness in the elderly, which was also occasionally given.

2.44 Hyoscine is an anticholinergic (atropine-like) drug used for excessive respiratory secretions or bowel colic. It is also sedating and can produce amnesia; the drowsiness and dry mouth caused by old-fashioned travel sickness remedies (many of which contain hyoscine) are due to their anticholinergic effects. Hyoscine was frequently given to patients at the hospital, usually in combination with diamorphine and midazolam. In some patients, especially the elderly, hyoscine can cause a 'central anticholinergic syndrome' with excitement, ataxia (loss of muscle coordination), hallucinations and behavioural disturbances.

2.45 Haloperidol is an antipsychotic drug used mainly in the treatment of schizophrenia and other psychoses. Its use in low doses is also well established for agitation and restlessness in the elderly. It has no analgesic effects and is only mildly sedating. Chlorpromazine, an antipsychotic drug of the phenothiazine group, which is also a powerful sedative, was also sometimes given for agitation and restlessness.

2.46 Thioridazine is another antipsychotic drug of the phenothiazine group. It was used mainly in schizophrenia but also to treat agitation and some of the symptoms of dementia. It was withdrawn from the market in all European Union member states in 2005 because of an unacceptably high risk of serious cardiac side effects.

2.47 Medication used in the hospital reflected the wide range of conditions of the patients admitted and included diuretics (for heart failure), antihypertensives, digoxin, antidepressants and anxiolytics, anti-inflammatory drugs for arthritis, and antibiotics.

2.48 A drug interaction occurs when the effect of one drug is modified by the prior or concurrent administration of another. The prescribing of opioids and other drugs in combination is known to expose patients to the risk of drug interactions. The pharmacology of drug interactions is complex. But the potential for increased sedation and respiratory depression when opioids and benzodiazepines are used together has been recognised and publicised since at least the

1980s. The impact may be additive: the combined effect is the sum or the part sum of the drugs individually. Or it may be supra-additive or synergistic: the combined impact is greater than the sum of the individual effects.

2.49 In general, the effect of these drugs when given together is at least additive, and may be synergistic.[14] The risk of using them in combination has been consistently documented in the BNF. In particular, it has long been known that when given together, opioids and midazolam cause enhanced sedation, respiratory depression and lowered blood pressure. Moreover, the effects of age and/or renal failure discussed above further increase the risk, as does co-administration of other sedatives such as hyoscine, chlorpromazine or thioridazine.

2.50 Phenothiazine antipsychotics such as chlorpromazine and thioridazine have been consistently shown to produce exaggerated falls in blood pressure and depressed respiration when given in combination with opioid analgesics. A comprehensive review of opioid interactions in 1993 concluded:[15]

> "The coadministration of phenothiazines and opioid analgesics to patients with tenuous pulmonary function is contraindicated in the absence of close respiratory monitoring."

The role of published clinical advice and guidelines

2.51 By the time of the first reported allegations and complaints at the hospital, there was a wealth of published advice and guidance on the safe use of opioids and other drugs acting on the nervous system. The principles of the development and use of clinical guidelines – which may be published internationally, nationally or locally – were well established.

2.52 Guidelines are developed through an expert consensus process in which the clinical evidence for treatments is rigorously evaluated. They are invaluable as a reference framework in planning the care of individual patients. They are particularly important in guiding the practice of less experienced clinicians, although experts in particular areas of therapeutics will also use them to underpin their clinical decision making.

2.53 As mentioned in paragraph 2.13, the BNF is the authoritative national compendium of advice on drug therapy. It is published jointly by the British Medical Association and the Royal Pharmaceutical Society of Great Britain. The BNF is compiled under the direction of a committee of experts nominated by both organisations, who take additional specific expert advice when necessary. It covers the whole spectrum of therapeutics and is aimed at a broad clinical audience.

2.54 The BNF is updated every six months to reflect current practice, and the Department of Health and Social Care funds its distribution free of charge to professionals throughout the NHS and to final year medical and pharmacy students. It is the principal source of general guidance on good prescribing practice in the UK and also in many other countries, and is invariably the first port of call when health professionals wish to check a choice of drug, doses, drug interactions or other aspects of prescribing.

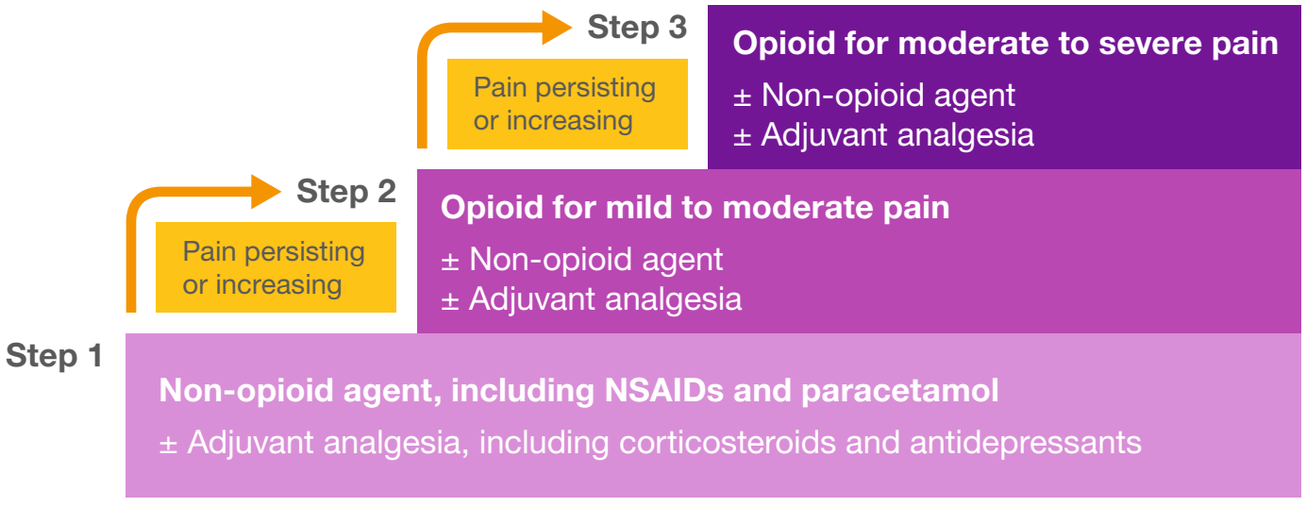
2.55 NHS organisations in the locality had adopted regional guidelines on the use of analgesics in palliative care by the time of the events at the hospital examined in this Report. The guidelines – *The Palliative Care Handbook: Guidelines on clinical management* – are sometimes

14 Maurer PM and Bartkowski RR, 1993. Drug interactions of clinical significance with opioid analgesics. *Drug Safety* 8, pp30–48.
15 Ibid.

referred to as the Wessex protocol or Wessex guidelines.[16] They were originally compiled by palliative care clinicians in the Bath District Health Authority, but were subsequently adopted across the Wessex Region of the NHS, including by Portsmouth HealthCare NHS Trust and Gosport War Memorial Hospital.

2.56 The concept of the analgesic 'ladder' is important in pain management. This is an international guideline introduced by the World Health Organization (WHO) more than 30 years ago, following consensus discussions in response to evidence of poor management of cancer pain in both developing and developed countries. This approach, which has very wide currency, encourages the use of opioids in severe pain but in a logical, stepped process of escalating use of analgesics in response to patients' symptoms.[17]

Figure 1: The analgesic 'ladder'



2.57 This approach is widely referred to as one of 'start low and go slow' with opioids. It is recommended in the Wessex guidelines. A recurrent criticism of opioid prescribing at Gosport War Memorial Hospital was the systemic failure to adopt the principles of the analgesic 'ladder'.

2.58 Even if there had not been clear guidelines in place, health professionals would have remained subject to their individual responsibility to deliver safe and effective care. Early guidelines issued by the National Institute for Health and Clinical Excellence (NICE) reinforced this point through the following statement:[18]

> "Your responsibility: This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering."

16 Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.

17 Vargas-Schaffer G, 2010. Is the WHO analgesic ladder still valid? Twenty-four years of experience. *Canadian Family Physician*, 56(6), pp514–17.

18 National Institute for Health and Clinical Exellence, 2007. *Acutely ill adults in hospital: recognising and responding to deterioration*. Clinical guideline CG50. www.nice.org.uk/guidance/cg50 (accessed 22 May 2018).

2.59 The summary of product characteristics (SPC) is a public document prepared by the manufacturer or distributor of a medicine but agreed by the licensing authority (UK health ministers for medicines licensed in the UK or the European Commission for those licensed on a pan-European basis). The SPC contains information on the dosage, use and side effects of the medicine.

2.60 It is unlawful for a manufacturer or distributor to market a medicine anywhere in the European Union without the corresponding SPC and a marketing authorisation (product licence) from the relevant authority. Health professionals may, however, lawfully prescribe and administer an unlicensed medicine, or a licensed one for an unlicensed ('off-label') indication (therapeutic use) when this is clinically necessary for their patient. Because the use of unlicensed medicines is often not supported by clinical trials that have been evaluated by regulatory bodies, there is a particular responsibility on prescribers to ensure that such medicines are clinically necessary and used safely.

2.61 Accordingly, the third (1995) edition of *The Palliative Care Handbook* (the Wessex guidelines) notes:

> "Some of the drugs are being used outside their product licences. Responsibility for the use of these drugs lies with the prescriber."

In the fourth (1998) edition this statement had been expanded to:[19]

> "Cautionary note: some of the drug usage recommended is outside product licence, either by way of indication, dose, or route of administration. However, the approaches described are recognised as reasonable practice within palliative care medicine in the UK."

2.62 The use of midazolam for terminal agitation was not covered by a marketing authorisation at the time of the events at the hospital, although it is now licensed for this indication in conjunction with an antipsychotic drug.[20] Palliative care professionals nevertheless recognised its use for this purpose as a valuable adjunct to end of life care in patients who needed it.

2.63 More recent NICE guidelines on strong opioids in palliative care[21] state:

> "Your responsibility: The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian."

2.64 Guidelines play an increasingly important role in clinical decision making. Although adherence to guidelines is not mandatory, clinicians who, in a patient's interest, diverge from agreed local or national guidelines should record the reasons for that decision, which they may

19 Forest Holme in association with all the Wessex Specialist Palliative Care Units, 1998. *The Palliative Care Handbook: Guidelines on clinical management*, fourth edition, p3.

20 National Institute for Health and Care Excellence, 2018. *Midazolam: Indications and dose*. https://bnf.nice.org.uk/drug/midazolam.html (accessed 5 May 2018).

21 National Institute for Health and Care Excellence, 2012. *Palliative care for adults: strong opioids for pain relief*. www.nice.org.uk/guidance/cg140 (accessed 5 May 2018).

have to defend if it results in harm to the patient. The Panel found that there were recurrent failures to record the clinical reasoning behind prescribing decisions at the hospital.

Summary of guidance in place at the time

2.65 By the time of the events at the hospital examined in this Report, the principles of safe and effective use of opioids, midazolam and other drugs in both palliative and non-palliative care were therefore clearly set out in authoritative international and national guidance. They were also reflected in local guidance issued in the Wessex Region of the NHS. This had been adopted by Portsmouth Hospitals NHS Trust, which provided medicines and associated pharmacy services to Gosport War Memorial Hospital (HCO111155).

2.66 The 1997 BNF does not make explicit reference to the WHO analgesic 'ladder', but its principles are implicit:

> "The non-opioid analgesics aspirin or paracetamol given regularly will often make the use of opioids unnecessary … Morphine is the most useful opioid analgesic … morphine is given by mouth as an oral solution every 4 hours, the initial dose depending largely on the patient's previous treatment … A dose of 5-10 mg is enough to replace a weaker analgesic … if the first dose of morphine is no more effective than the previous analgesic it should be increased by 50%, the aim being to choose the lowest dose which prevents pain … the equivalent intramuscular (or subcutaneous) dose of diamorphine is only about a quarter to a third of the oral dose of morphine; subcutaneous infusion via syringe driver can be useful."

2.67 It also states that older people, especially the very old, require special care and consideration from prescribers. The 1998 edition of *The Palliative Care Handbook* (the Wessex guidelines) states: *"The WHO analgesic ladder has been adopted to emphasise that it is essential to use an analgesic which is appropriate to the severity of the pain."* It then sets out clearly the three-step approach. Step one uses non-opioid analgesics – paracetamol or non-steroidal inflammatory drugs such as ibuprofen, diclofenac or naproxen. Step two uses weak opioids such as codeine, co-codamol (a combination of codeine and paracetamol) or dihydrocodeine. Step three introduces strong opioids – morphine, diamorphine and fentanyl.

2.68 The handbook stresses that accurate and full assessment is essential for both diagnosis and treatment; that appropriate therapies should be used to maintain the best possible quality of life and maximum independence for patients; that patients should be continually reassessed; and that care should be taken that drug side effects do not become worse than the initial problem. When opioids are given, the guidance recommends using continuing pain as an indication to increase the dose, and persistent side effects such as drowsiness, confusion or vomiting as an indication to reduce the dose.

2.69 Oral morphine (tablets or liquid) is recommended in a low starting dose of 5 mg every four hours, increasing by 30–50% each day until pain is controlled or side effects prevent further increases. The guidance indicates that only a minority of patients (and this is aimed at people in end of life care) will need more than 30 mg every four hours (equivalent to 60 mg of infused diamorphine per 24 hours). Diamorphine by continuous infusion using a syringe driver is suggested when patients cannot take oral medicines because of dysphagia (difficulty swallowing), vomiting or weakness.

2.70 There is no suggestion in the guidance that opioids should be used to treat anxiety, confusion or terminal restlessness. In fact, the sections on confusion and terminal restlessness clearly list opioids as a cause or risk factor, particularly when exacerbated by renal failure.

Pharmacy services at the hospital

2.71 Portsmouth Hospitals NHS Trust, the local acute hospital, provided pharmacy services to Gosport War Memorial Hospital under a service level agreement (DOH800198). This included the procurement and supply of medicines required at the hospital, together with advice on their use, security and custody. A senior pharmacist managed the contract and a second pharmacist provided the service. These arrangements appear broadly to have followed standard NHS pharmacy practices for remote non-acute hospitals at the time.

2.72 Portsmouth Hospitals NHS Trust and its chief pharmacist therefore had overall responsibility for pharmacy services at Gosport War Memorial Hospital. The chief pharmacist was responsible for oversight of the procurement, control, storage and distribution of drugs for all Portsmouth hospitals; ensuring that there were procedures in place to maintain adequate and safe drug stocks in each ward area; and checking that drugs were stored securely.

2.73 The chief pharmacist was also responsible for: ensuring that advice and support was provided to ward staff; training and development of the hospital's pharmacists; and, with the support of clinical staff and the Drugs and Therapeutics Committee, ensuring that prescribing guidelines were adhered to and that the drug charts being used in the hospital (see paragraphs 2.81 to 2.89) were fit for purpose, safe and in line with national policy and guidance.

2.74 The Trust had a Drugs and Therapeutics Committee, of which the chief pharmacist was a key member. The committee had broad oversight of prescribing policy and practice, including the appropriateness and affordability of new drugs introduced in the hospital.

2.75 Up until about 1994, the hospital had its own pharmacy department located within the outpatients department on the main hospital site. It had been well established for many years and was staffed several days per week by a pharmacist from Portsmouth Hospitals NHS Trust who made ward visits throughout the hospital, including checks on controlled drugs. This facility was removed in the redevelopment and the on-site pharmacy was replaced by the remote service from Portsmouth.

2.76 Portsmouth Hospitals NHS Trust subsequently supplied medicines direct to wards at the hospital in locked boxes, against signed orders from a senior nurse on each ward. In line with universal good practice in the NHS, there was an additional system for signed orders, secure transit, and signed handover and receipt of controlled drugs on the wards.

2.77 Pharmacist visits to the hospital continued twice a week and included checks on ward stocks and examinations of patients' drug charts. The system was primarily aimed at maintaining adequate supplies, but there was also a mechanism for raising concerns. The community services pharmacist for the hospital, said:

> "Daedalus ward would have been visited on a Thursday and that visit involves looking through the medical charts and checking for supplies and just generally checking whether things are appropriate … as I go through the charts I would also check for relevance of the medicines that are prescribed." (HCO109728)

2.78 The route for raising concerns was via the senior nurse to the clinical assistant or consultant. There was no systematic process for review of prescribing (HCO109728). In the report of its investigation into the hospital and Portsmouth Hospitals NHS Trust, the Commission for Health Improvement (CHI) described:

> "… a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital … 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 … it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned." (CQC100951, p33)

2.79 The CHI report, using the Trust's own medicines usage data, noted the excessive use of diamorphine and midazolam, which reached a peak in 1998/99. Over that period, Dryad, Daedalus and Sultan wards used 1,617 doses of diamorphine and 1,680 doses of midazolam. With a patient population that was in the main not admitted for palliative or end of life care, this was clearly excessive. Even superficial monitoring of pharmacy data should have sounded alarm bells.

Prescribing practices at the hospital

2.80 A number of statutes and policies govern the prescribing and administration of drugs in NHS hospitals. These are: the Medicines Act 1968 and its secondary legislation (more recently the Human Medicines Regulations 2012); the Misuse of Drugs Act 1971 and its regulations; and Department of Health and Social Care and local NHS guidance. Strictly speaking, hospitals are exempt from many elements of medicines legislation – for example, the legal concept of a 'prescription-only medicine' applies only in the wider community and not in hospitals. Nevertheless, a body of good practice and guidance has accrued over many years from successive governments and professional bodies that requires NHS hospitals to adhere to the spirit of the legislation in order to protect patients and the wider public interest.

2.81 Drugs prescribed for inpatients are written on forms designed specifically for this purpose, often referred to as drug charts. More recently, many hospitals have developed systems of electronic prescribing, but paper-based systems were used almost universally in the 1990s.

2.82 Hospitals or groups of hospitals design and source charts to meet their own requirements, including those of specialised units within hospitals. There is no 'national drug chart'. However, drug charts have evolved over many years to embody good prescribing and recording practice. They follow similar principles and have similar layouts.

2.83 Drug charts are filed with each patient's clinical records. They are both an essential working tool for prescribing and monitoring drug treatment during a patient's stay, and an important historical record of that treatment, which may be valuable in further episodes of care. When patients are discharged to home or residential care, a 'to take out' prescription is usually written. Details of this are included in the discharge summary sent to the patient's GP, and the drug charts are then archived with other clinical records for that patient. A summary of the drug chart would also accompany the patient if he/she was transferred between hospitals, for example from Queen Alexandra Hospital or Royal Hospital Haslar to Gosport War Memorial Hospital.

2.84 A drug chart nearly always has three distinct components, which reflect the three main ways in which drugs are prescribed in hospitals: drugs to be given regularly; drugs to be given when required; and drugs to be given once only. Drugs given regularly comprise the majority of hospital prescribing. The chart records the name and dose of the drug, its route of administration and the times when it is to be given.

2.85 In most circumstances, the dose of the drug is fixed and not left to the discretion of the nurse. On occasions some flexibility in dosage is prescribed to allow for changing clinical needs, for example with analgesics or night sedatives. The name of the prescriber is recorded and any subsequent changes (for example, to the dose) are also recorded and signed or initialled by the prescriber. An important feature of a drug chart is that the person administering the drug records the date and time of every dose. This provides a comprehensive record of the patient's treatment. Instances where the drug is not given are also captured.

2.86 Drugs to be given on an 'as required' basis are recorded in a separate area of the chart. They are often still referred to as 'PRN' medications, an abbreviation of the formerly used Latin term *pro re nata* (as circumstances require). The prescriber again records the drug, dose, route of administration and frequency of dosing. The decision to administer the PRN therapy is then left to the discretion of nursing staff responsible for that patient. Any changes to the prescription are recorded and signed or initialled, and the date and time of each dose is recorded.

2.87 This is an example of 'anticipatory prescribing'; that is, prescribing a drug in advance to meet a possible future clinical need. Anticipatory prescribing is now well established in palliative care medicine and there is an extensive body of literature on its safe and effective use to benefit patients. However, its use was not well established in the 1990s. At the heart of the families' concerns are the scale and extent of this practice at the hospital; the dose ranges prescribed; the degree of delegation to nurses to start treatment and increase doses; and the dangers inherent in this practice.

2.88 Drugs that are given only once are recorded in the third part of the drug chart. These might include, for example, a single dose of a drug to treat an epileptic fit, or a dose of a tranquilliser to settle a disturbed patient.

2.89 The records show that the drug charts in use at the hospital reflected the principles and design outlined above. In addition to the detailed records created in the drug charts, notes of the initiation of drug treatment and/or any changes were usually made in the narrative recorded in the clinical notes and the separate nursing notes.

2.90 For controlled drugs such as diamorphine there was an additional set of records. All hospital wards and departments are required to keep a controlled drug register. This is a hardback book (electronic registers are also now permitted in some settings) with separate sections for each drug and dosage form. All controlled drugs received by the ward must be entered, and every dose administered to a patient and the name of the person giving it (as well as any wastage) is also recorded. A running balance is maintained so that any discrepancies or diversion of controlled drugs can be readily identified.

2.91 There are therefore four discrete sources of information on the drugs given to individual patients at the hospital. The Panel has found that, from the data it has been able to access, one or more of these sources is often incomplete or missing altogether. But wherever possible, all these sources have been used in the analysis.

The Panel's analysis of drugs used at the hospital

2.92 Panel members, supported by expert nurses recruited for the purpose, have reviewed the clinical records of the Initial Group of patients and the Wider Group of patients (see paragraphs 2.3 and 2.4).

2.93 The Panel considered 45 questions as part of the drug analysis. These were answered by reviewing the contemporaneous clinical and nursing notes, along with those drug charts and controlled drug registers that were available. The Panel addressed the questions for all 163 patients in the Initial Group of patients and 30 patients in the Wider Group of patients, as described in Appendix 1.

2.94 The Panel was concerned by the use of opioids at the hospital – as were some experts whose work will be covered in later chapters of this Report. The Panel's analysis was independent of those earlier expert reports. Indeed, the Panel decided not to consider the earlier expert witness statements until it had completed its own clinical analysis.

2.95 The nature of what the Panel found can be seen in Table 1, which summarises the treatment and cause of death of the Initial Group of patients. This is published with the permission of the families.

Table 1: Summary findings from clinical records of patients in the Initial Group

This table can be found at the back of the Report, following Appendix 3.

The main findings from the Panel's analysis of the documents

2.96 The Panel's main findings from its analysis of the documents relating to the prescribing and administering of drugs are as follows:

- Finding One: Opioid usage without appropriate clinical indication
- Finding Two: Anticipatory prescribing with a wide range of doses
- Finding Three: Continuous opioid usage for patients admitted for rehabilitation or respite care
- Finding Four: Continuous opioids started at inappropriately high doses
- Finding Five: Opioids combined with other drugs in high doses
- Finding Six: Few patients survived long after starting continuous opioids
- Finding Seven: Prescription and administration of drugs contravened guidelines
- Finding Eight: Occurrence and certification of deaths.

These have been formulated through privileged access to medical records and supporting documentation granted to the Panel alone. As such, the process has not involved any other party.

Finding One: Opioid usage without appropriate clinical indication

2.97 The first finding, opioid usage without appropriate clinical indication, is the critical turning point on which the other findings, in this chapter and elsewhere, depend. As already noted, opioids are powerful drugs that bring significant benefits when used appropriately, but they carry commensurate risks.

2.98 The Panel looked at all the clinical records available for those 163 patients it initially knew about (see paragraph 2.3), to examine opioid usage. It collected information on the prescribing and administration of drugs, together with clinical information. In 58 cases, the clinical records, or key parts of them, could not be found; in the remaining 105, the Panel looked at whether opioids were used without appropriate clinical indication, taking into account the clinical picture, previous use of analgesics, reasons for starting continuous opioids, escalation of dosage and the use of other medication and alternatives. In many, the clinical records were of poor quality, hampering the search for evidence. Nevertheless, for 71 patients there was evidence that opioids were used without appropriate clinical indication.

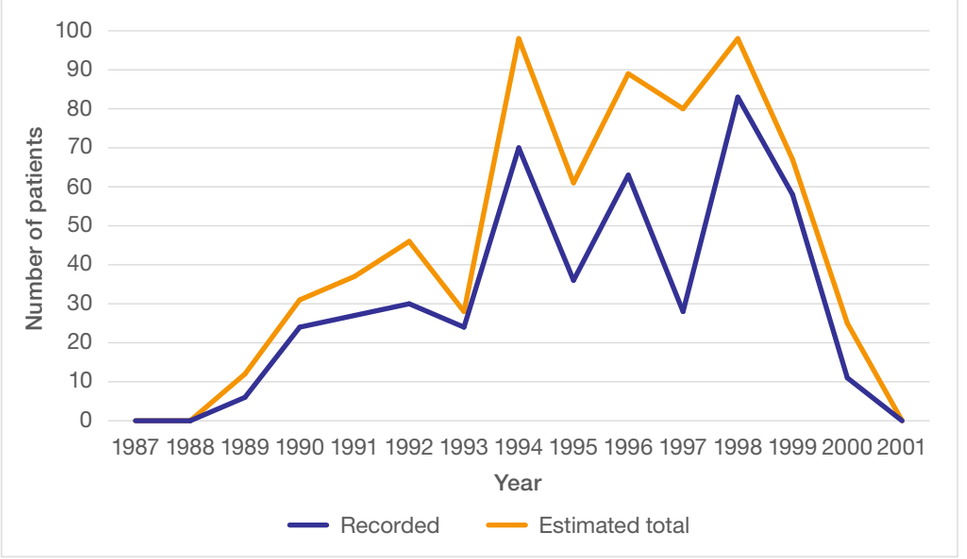
2.99 The starkness of this finding raised concern that patients other than those of whom the Panel was initially aware might also have been affected. It therefore sought the clinical records of the 2,024 patients known to have died in the hospital between 1987 and 2001, a period which appeared to cover the start and end of the pattern of opioid prescribing of concern. Hospital records for 1,564 of these patients were found, and it was considered whether opioids had been used without appropriate clinical indication.

2.100 In 1,043 of this Wider Group of patients there was sufficient information to form a view, although the Panel was again hampered by the poor quality of the clinical records. In 385 of these, there was evidence of opioid usage without appropriate clinical indication. A more detailed examination of the records of 30 of the Wider Group, described in Appendix 1, found that opioid use showed the same features as those in the Initial Group of patients.

2.101 In total, the Panel found evidence of opioid usage without appropriate clinical indication in 456 patients – that is, in 40% of the records that contained sufficient information. Taking into account the missing records, there were probably at least another 200 patients similarly affected but whose clinical notes were not found.

2.102 The occurrence of opioid usage without appropriate clinical indication followed a striking pattern over time (see Figure 2). There were no instances found in 1987 or 1988, but from 1989 the numbers rose strikingly. This was followed by an equally striking decline over 1999 and 2000, with no instances in 2001.

Figure 2: Opioid use without appropriate clinical indication, 1987 to 2001, numbers per year

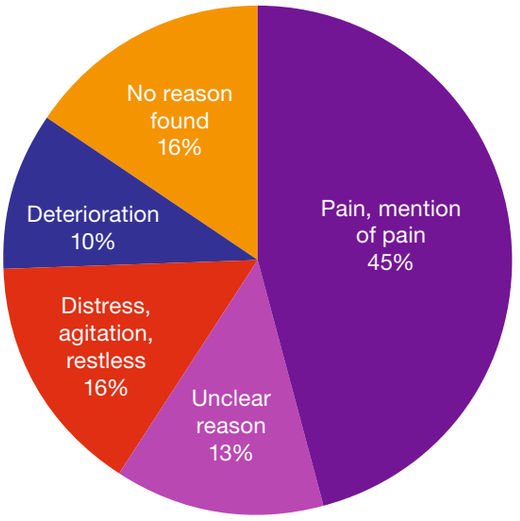


2.103 In the great majority of patients, the opioid was diamorphine administered via a syringe driver, often in conjunction with other drugs, particularly midazolam and hyoscine, over the last few days of life. This corresponds closely with the concerns expressed by families.

2.104 It is important to note that opioids, including diamorphine, are central to the management of acute or chronic pain, as set out in paragraph 2.12; occasionally opioids might be used for indications other than pain, such as breathlessness or cough. Only 45% of the Initial Group of patients with complete drug information had any suggestion of pain recorded in their notes (see Figure 3); in the majority of these, strong opioids would not have been clinically indicated as the first choice, or in the doses given.

2.105 The other stated reasons for diamorphine administration in the Initial Group would rarely, if ever, be regarded as appropriate indications, including deterioration, distress, restlessness and agitation. In 29%, no reason was found or no clear rationale was stated in the clinical records.

Figure 3: Recorded reason for administering diamorphine (97 patients in Initial Group given diamorphine)



Finding Two: Anticipatory prescribing with a wide range of doses

2.106 Anticipatory prescribing, or pre-prescribing, is the prescribing of a drug before it is necessary, so that it can be administered as soon as it is needed. When done appropriately, as part of a specified care plan with a defined reason to start and increase dosage within reasonable limits, it is a well-regarded part of end of life care. This is, however, very different from its use in patients admitted for a range of reasons other than end of life care, with no recorded decision on end of life care, and no recorded 'triggers' to start or to escalate dosage. There was no evidence in the documents seen by the Panel of the use of any guidance on those wards during the 1990s on the use of anticipatory prescribing or the need for careful controls.

2.107 More usually, opioids would be prescribed as a fixed dose to be given at regular intervals with, perhaps, additional amounts if required to control pain. The decision to administer any additional amounts would be made by a trained nurse and recorded in the clinical records with the reason they were necessary.

2.108 In contrast, the records show that practice at the hospital included anticipatory prescribing of diamorphine by syringe driver in a very wide dose range of either 20–100 mg per

24 hours or, more commonly, 20–200 mg per 24 hours, with no specified trigger for the start or escalation of dosage. In some, prescribing was done on the day of admission of patients not admitted for end of life care (see Table 2). This is contrary to all existing guidance at the time, including the Wessex guidelines and the BNF (1997). The records show that this was the reason that many patients did not receive opioids until several days after they had been prescribed.

Table 2: Inappropriate use of anticipatory prescribing of diamorphine on day of admission when not clinically indicated

Dosages prescribed	Number of patients
Range: 20–100 mg/24 hr	4
Range: 20–200 mg/24 hr	9
Other	1
Total	14

2.109 The use of anticipatory prescribing of opioids before a patient requires end of life care carries significant risks and places unreasonable responsibility on nursing staff. First, as evidenced in some patient records, a change in the patient's condition could be misinterpreted as a terminal event, prompting the start of a potentially lethal drug regime. Second, again as evidenced in some patient records, opioids already prescribed in this way could be used as an inappropriate response to a patient's agitation or challenging behaviour. It is notable that in some cases the depressed consciousness that resulted from such inappropriate administration of opioids and other powerful sedatives was then ascribed, with no supporting evidence, to pathological changes such as stroke, and the drug regime was continued or increased.

2.110 The very wide dose range prescribed also placed additional undue responsibility on nursing staff who had to judge what dose to administer and when to increase it. The clinical notes did not include a record of what indications to use when making such a decision. Equally significantly, the nursing notes show little information about the reasons for escalation of the dose.

Finding Three: Continuous opioid usage for patients admitted for rehabilitation or respite care

2.111 The documents reviewed by the Panel show that the practice of pre-prescribing opioids extended to patients who had been admitted for rehabilitation or respite care.

2.112 While there may be reasons to consider anticipatory prescribing under carefully controlled conditions for end of life care, as noted in paragraph 2.106, this is very different from pre-prescribing opioid medication for patients who have been assessed as requiring rehabilitation or a period of respite care. The finding in clinical records that this happened repeatedly in patients admitted for rehabilitation or respite care was particularly surprising. These were patients, albeit frail, who had planned admissions but who were given powerful medication capable of suppressing consciousness and respiration.

2.113 Of the 163 Initial Group of patients in Table 1, there was sufficient information in the clinical records available to allow detailed analysis of prescribing, administration and reason for admission in 116 patients; 54 of these had been admitted for either respite care or rehabilitation. Diamorphine was prescribed for 49 (91%) of these patients, and administered in 47 (87%). A total of 35 (65%) received a combination of continuous diamorphine, midazolam and hyoscine.

2.114 The repeated finding of diamorphine usage in patients with a stroke was also of concern. Pain after a stroke is not usually of sufficient severity to warrant morphine or diamorphine; painful muscle spasm is common but usually managed with standard non-opioid analgesics or antispasmodics, with tricyclic antidepressants or antiepileptic therapy for less common pain of neurological origin. Yet some patients admitted to the hospital after a stroke received diamorphine, with minimal evidence in the clinical notes that these patients had severe pain. Others were given opioids and, when their consciousness was unsurprisingly reduced, diagnosed as having suffered a probable stroke. However, there was no record of any examination for neurological signs of a stroke.

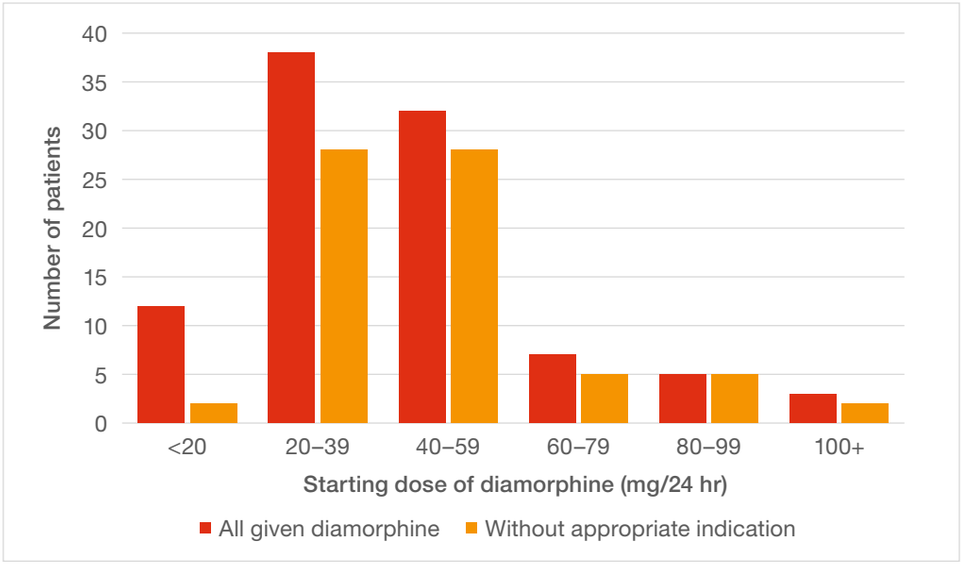
Finding Four: Continuous opioids started at inappropriately high doses

2.115 Established guidance on the use of pain relief is clearly based on an incremental approach, in which less potent and risky drugs are tried first, with progression to the most potent continuous opioids only when necessary for severe intractable pain not controlled by other agents. When continuous opioids are used, they should not be the first line of treatment, and the dose should be carefully controlled. This is the basis of the WHO analgesic 'ladder' (see Figure 1) and the local Wessex guidelines.

2.116 The records show that diamorphine was often used without prior use of less potent analgesics, contrary to the guidance. Of the 97 patients in the Initial Group administered diamorphine, 23 (24%) had had no prior opioid of any description. Although the remainder had had some form of opioid, including oral morphine, modified release morphine or fentanyl, in many cases this had been given for too short a period for the effects to be assessed prior to escalating treatment to continuous diamorphine via a syringe driver.

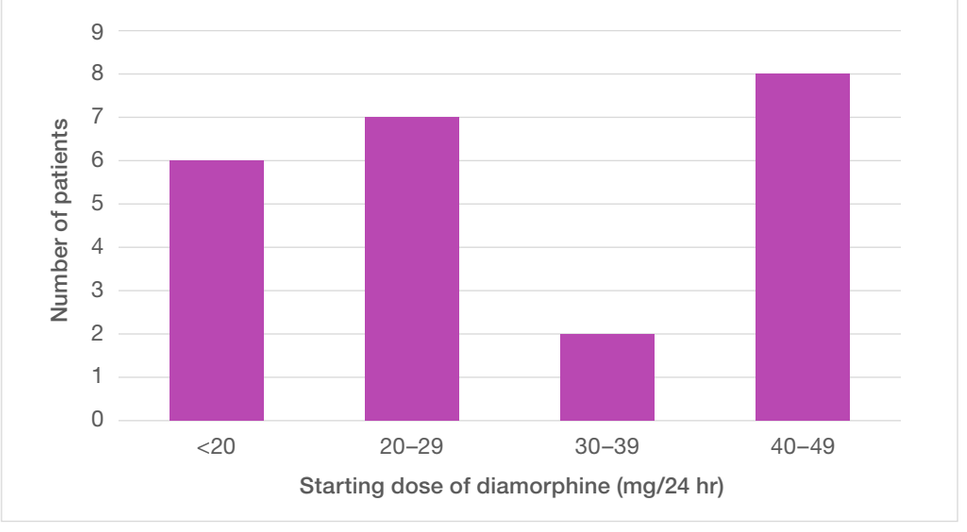
2.117 When continuous diamorphine was used, the initial dose was often high, most commonly 20 mg per 24 hours or 40 mg per 24 hours as shown in Figure 4. Diamorphine was commonly prescribed in a wide dose range with a lower limit of 20 mg per 24 hours, but it is notable that in almost half (48%) an initial dose of 40 mg per 24 hours or higher was selected. Although the range prescribed often went as high as 100 mg per 24 hours or even 200 mg per 24 hours, it is remarkable that so many patients were judged to require such a high initial dose. This is even more striking for those patients in whom there was no appropriate clinical indication for the diamorphine usage, with 57% receiving an initial dose of 40 mg per 24 hours or higher.

Figure 4: Starting dose of diamorphine in all patients given the drug in the Initial Group (97) and in those patients with evidence that diamorphine had been given without appropriate clinical indication



2.118 There are occasions when high levels of continuous opioids are necessary and appropriate, such as when patients in severe pain have developed a tolerance to the drug. This usually occurs when patients have been receiving continuous morphine or diamorphine as part of end of life care with an escalating dose carefully titrated against pain level and tolerance. There are, however, occasions when patients are switched from another opioid, such as oral morphine or fentanyl patches, and may need a higher initial dose as a result, but this is insufficient to explain the remarkably high starting doses in these patients. Figure 5 shows the starting dose of diamorphine for 23 patients who went straight to diamorphine with no preceding other opioid and were therefore particularly susceptible to the effects. A similar pattern is evident, with 8 of the 23 starting on 40 mg per 24 hours.

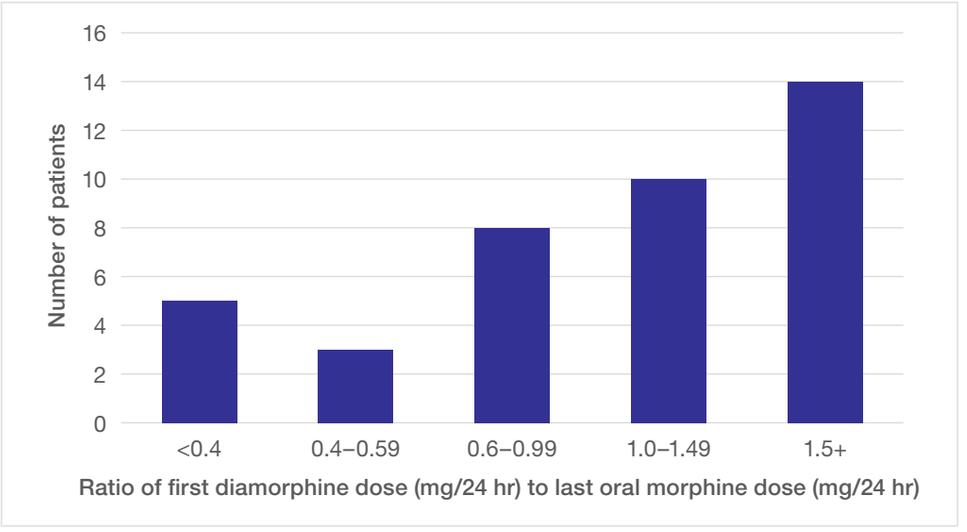
Figure 5: Starting dose of diamorphine in those who had had no prior form of opioid



2.119 Where a prior opioid had been used (70 patients), this had sometimes been for such a short period that there was neither time for its effect to be assessed nor for a tolerance to develop that might have justified a higher initial dose of continuous diamorphine. Some 23% of this group had received another form of opioid for only one day or less before being switched to continuous diamorphine.

2.120 In 40 patients who had been given oral morphine for longer, the records of drug administration were sufficiently complete to allow a comparison to be made between the last dose of oral morphine and the initial dose of diamorphine that followed (Figure 6). As the most relevant guidance (BNF) makes clear, parenteral diamorphine has approximately three times the potency of oral morphine preparations. To maintain equivalence when making this switch, the dose of diamorphine should have been one-third of the dose of oral morphine over a 24-hour period. No fewer than 35 (88%) patients in this group received an initial dose in excess of this and therefore outside the guidelines; in several cases the initial dose of diamorphine was four or more times larger.

Figure 6: Relationship between first dose of diamorphine and preceding dose of oral morphine



Note: The ratio of first diamorphine dose (mg/24 hr) to last oral morphine dose (mg/24 hr) should usually be within the first bar (<0.4); ratios higher than this contravene guidance.

Finding Five: Opioids combined with other drugs in high doses

2.121 Not only were patients started on diamorphine in high doses contrary to the guidance, in many cases diamorphine was combined in the syringe driver with other drugs, most commonly midazolam and hyoscine. As already seen, midazolam is a powerful sedative, used to reduce anxiety, but in concert with diamorphine it acts to suppress consciousness. Hyoscine, used to reduce bronchial and other secretions, also has a suppressive effect on consciousness.

Table 3: Number of patients given diamorphine, midazolam and hyoscine, and all three drugs (percentages of total group)

Drugs administered: all patients (116)	Number of patients	Percentage of total group
Diamorphine	97	84%
Midazolam	78	67%
Hyoscine	71	61%
All three drugs	63	54%

2.122 Table 3 summarises the drugs given via syringe driver to 116 patients from the Initial Group. A large majority received more than one drug, and more than half received all three drugs. The clinical records contain few references to either a need for sedation or signs or symptoms suggesting a need to reduce secretions. Given the high doses of diamorphine prescribed, often without appropriate clinical indication, the addition of further drugs with few references to any clinical requirement for them is remarkable. It is not surprising that excessive levels of sedation were often a feature of what clinical records there were, and it is likely that all three drugs played a part in this when used in combination. It is equally surprising that, considering the amount of opioids being used, there is not a single example in any of the records we have seen where the antidote to opioids, namely naloxone, was considered.

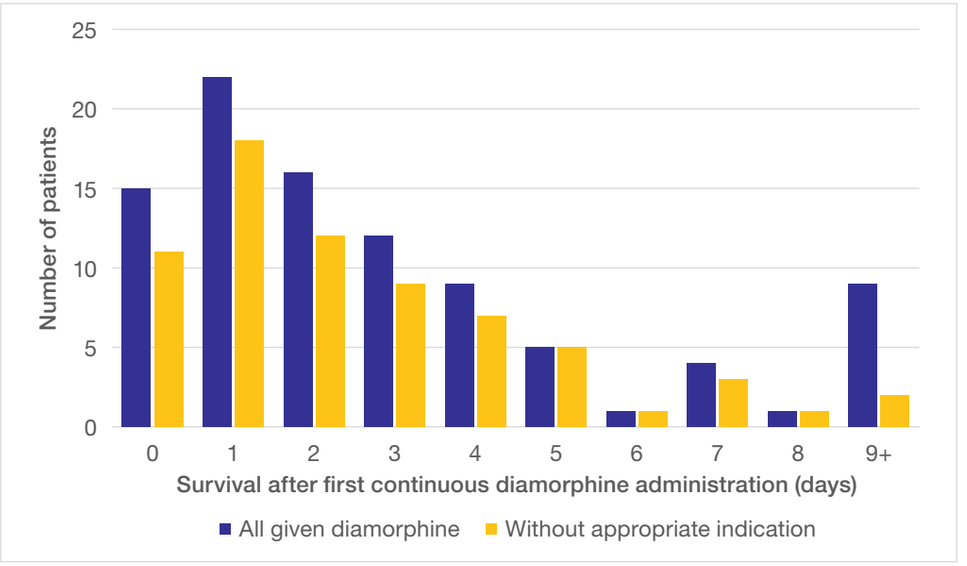
Finding Six: Few patients survived long after starting continuous opioids

2.123 The survival of patients who were started on continuous diamorphine via syringe driver was inevitably measured in days, usually very few. Figure 7 shows the interval between starting diamorphine and death in the Initial Group of patients: 56% survived for two days or less.

2.124 Many of these patients were frail and elderly, and some may have been unlikely to survive for a prolonged period; this would be particularly true for those who were given continuous opioids for intractable pain as part of end of life care. Almost three-quarters of this group of patients, however, were given continuous diamorphine without appropriate clinical indication, and it is unlikely that significant numbers of that group would otherwise have succumbed within two days, however frail and elderly.

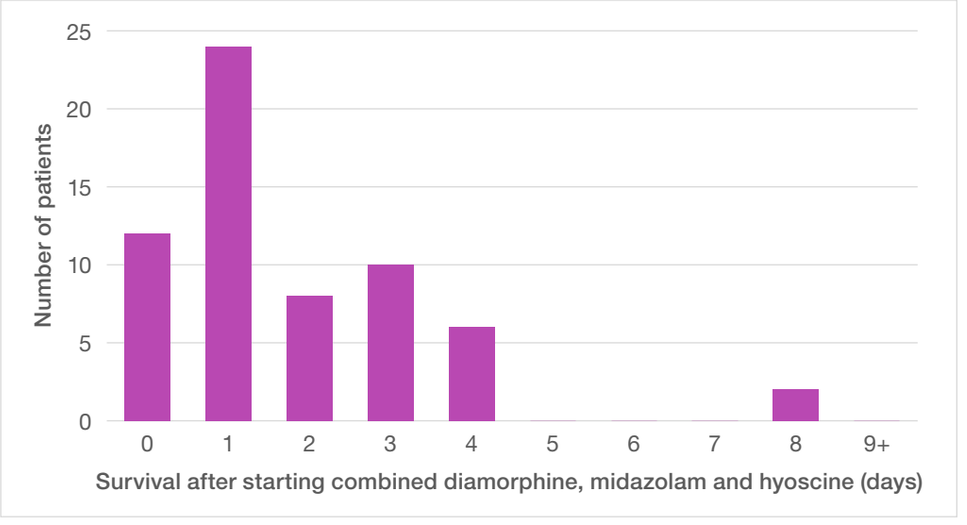
2.125 Figure 7 also shows the survival of those administered continuous diamorphine without appropriate clinical indication (yellow bars). The pattern was at least equally as striking: 59% were dead in two days or less.

Figure 7: Survival after starting continuous diamorphine administration



2.126 When diamorphine was combined with midazolam and hyoscine, survival was even briefer (Figure 8). Of patients given all three drugs, 71% were dead in two days or less, with half dying on the same or the next day.

Figure 8: Survival after starting combined diamorphine, midazolam and hyoscine



Finding Seven: Prescription and administration of drugs contravened guidelines

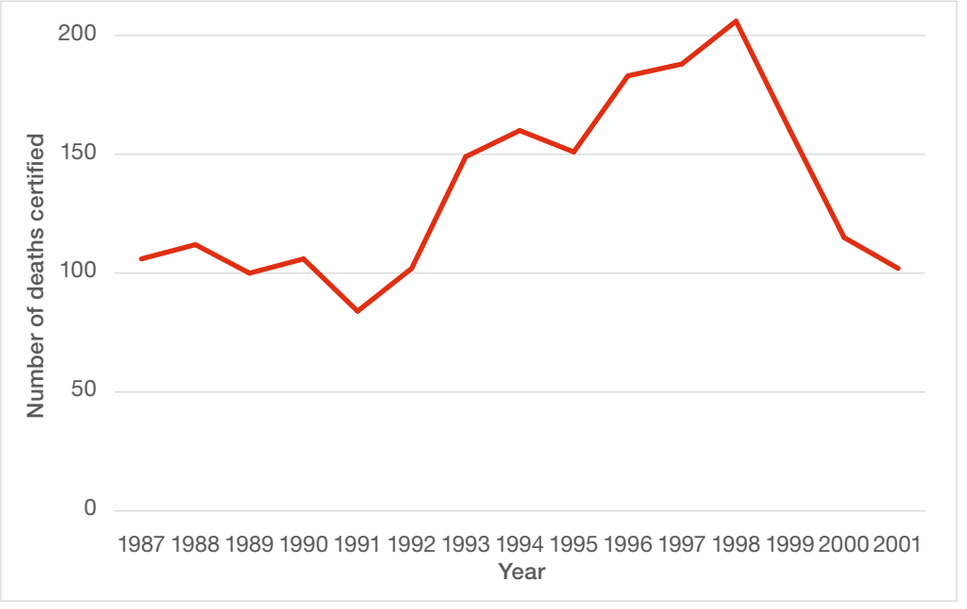
2.127 The Panel's analysis shows that the practice of prescribing and administering drugs at the hospital conflicted with the national and local guidance that applied at the time.

2.128 Paragraphs 2.87 and 2.106 describe the background to anticipatory prescribing. The failure to follow the relevant guidance extended to record keeping on the wards: the available records show that drug dosage was not always recorded in full on the drug chart. This is further considered in Chapter 3.

Finding Eight: Occurrence and certification of deaths

2.129 The Panel retrieved death certificate information for patients who had died in the hospital between the start of 1987 and the end of 2001 – 2,010 in all. The occurrence of deaths followed a striking pattern over time, as shown in Figure 9. Until 1992, the number of deaths per year was fairly steady, around 100 per year, but from 1993 to 1998 the annual death rate rose steadily to reach just over 200 in 1998, double the earlier figure Equally remarkably, annual deaths fell rapidly over 1999 and 2000 and had reached the former baseline of 100 per year by 2001.

Figure 9: Deaths certified at Gosport War Memorial Hospital, 1987 to 2001



2.130 When the rising pattern of deaths was noted previously, two possible explanations were put forward. It was suggested that either the number of patients admitted had increased over the period, or the type of patients had changed, with more admitted for end of life care. There is some evidence that admissions increased, as happened in most hospitals over that period, but information is lacking to test either suggestion directly. Neither suggestion is sufficient to account for the pattern.

2.131 First, the rise in deaths was followed by an even more rapid decrease, returning to the previous baseline in two years. To achieve either a reduction in admissions or a change of case-mix sufficient to reverse the rise in two years, a marked change in policy would have had to be implemented in the hospital. There is no recorded evidence of any such policy being considered or implemented.

2.132 Second, the rise in deaths corresponds with the time period in which the number of patients given opioids without appropriate clinical indication was at a high level (see Figure 2), whereas an increased need for appropriate opioid administration would have resulted in a steady or decreased number being given opioids without appropriate clinical indication.

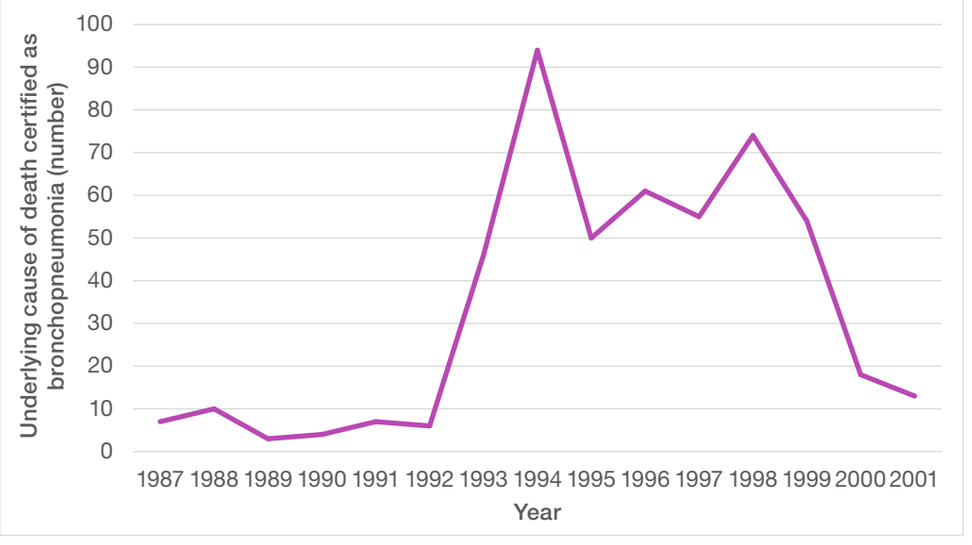
2.133 The recorded causes of death for those who died in the hospital are also instructive. The most notable feature immediately apparent on examining the death certificates was the frequent occurrence of bronchopneumonia as a cause of death: bronchopneumonia was cited as the immediate cause of death in 796 patients (39%). Bronchopneumonia is a poorly defined infection of the lungs and small airways that may occur as a terminal event in some patients

who are very ill, immobile and have reduced consciousness. It is usually accompanied by altered chest sounds and sometimes a raised temperature. Under these circumstances, it is not a cause of death that would generate surprise. Without a clear underlying cause and in the absence of clinical signs, however, it would be an inappropriate cause of death to certify.

2.134 Medical certificates of cause of death allow for recording a chain of three direct causes, the first due to or as a consequence of the second, which itself may be due to or as a consequence of the third. The first recorded is the immediate cause of death, while the last completed line is the underlying cause of death; they may be the same if only the first line is completed. There is also scope to record one or two contributory causes which did not themselves directly lead to death. The underlying cause of death was recorded as bronchopneumonia in 503 patients (25%). It is notable that a quarter of all patients who died in the hospital over this period had no other certified cause leading to death than bronchopneumonia, even more so given the lack of clinical findings that would point to this diagnosis in those clinical records examined by the Panel.

2.135 Further, the pattern of deaths certified as due to an underlying cause of bronchopneumonia follows broadly the same trend over time as that for all deaths and for the use of opioids without appropriate clinical indication (see Figure 10). This is contrary to the pattern that would have been expected had the rise and subsequent rapid fall in deaths over this period been related to an increase in admissions of more severely ill patients for end of life care. It is also notable that certifying deaths as due to bronchopneumonia was related to opioid usage: in those with evidence of opioid usage without appropriate clinical indication, 30% had bronchopneumonia given as the underlying cause, whereas in those without such evidence the corresponding figure was 11%.

Figure 10: Underlying cause of death certified as bronchopneumonia, 1987 to 2001

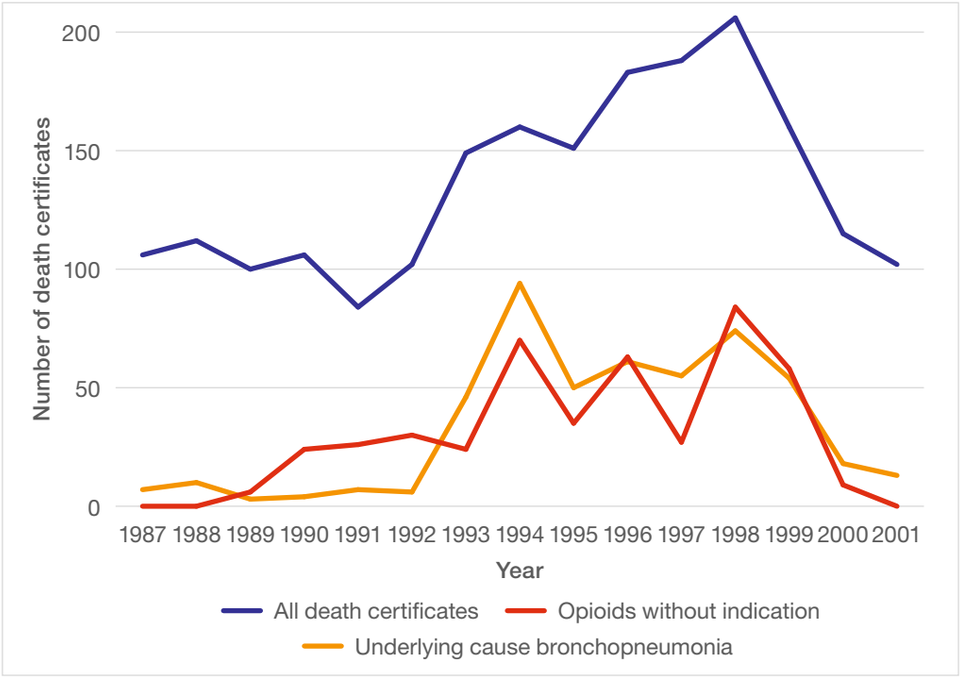


2.136 Given the evidence that the rise in deaths over the period 1993 to 2000 was a real increase, it is notable that the number of deaths above those expected from the previous and subsequent baseline amounts to around 500, which is comparable with the 450 to 650 occurrences of use of opioids without appropriate clinical indication described previously.

2.137 Finally, it is notable that the overall trend evident in Figure 10, rising from a low baseline in 1992 to a higher plateau from about 1994 to 1998 before falling rapidly back to the baseline

in 2001, closely mirrors both the overall number of deaths and the occurrence of diamorphine usage without appropriate clinical indication. These are shown together in Figure 11.

Figure 11: Occurrence of all deaths, opioid use without appropriate clinical indication and certification of bronchopneumonia as underlying cause of death, 1987 to 2001



Conclusion: what is added to public understanding

- By the time of the events at Gosport War Memorial Hospital examined in this Report, the principles of safe and effective use of opioids, midazolam and other drugs in both palliative and non-palliative care were clearly set out in authoritative international and national guidance. These were also reflected in local guidance issued in the Wessex Region of the NHS. These had been adopted by Portsmouth Hospitals NHS Trust which provided medicines and associated pharmacy services to Gosport.

- The Commission for Health Improvement report, using the Trust's own medicines usage data, noted the excessive use of diamorphine and midazolam which reached a peak in 1998/99. Over that period, the Commission for Health Improvement noted that Dryad, Daedalus and Sultan wards used 1,617 doses of diamorphine and 1,680 doses of midazolam. With a patient population that was in the main not admitted for palliative or end of life care, this was excessive. Even superficial monitoring of pharmacy data should have sounded alarm bells.

- The Panel has found that the records show that 456 patients died where medication – opioids – had been prescribed and administered without appropriate clinical justification. The review of evidence conducted by the Panel suggests that, taking into account the missing records, there may have been a further 200 such deaths, bringing the overall total to around 650.

- The Panel's analysis reveals that the dose range prescribed was too wide, completely contrary to national guidance, and ignored both the British National Formulary and the Wessex guidelines in operation at the time.

- The practice of prescribing and administering drugs at the hospital conflicted with the national and local guidance which applied at the time.

- The Panel found that survival was short once continuous diamorphine had been started, less than three days in the majority of relevant cases, and this was equally true in those who had received diamorphine without appropriate clinical indication.

- Pre-prescribing opioids has a part to play, after careful evaluation, in the palliative care of patients assessed as being at the end of their lives. This is very different from pre-prescribing opioid medication for patients who have been assessed as requiring a period of respite care. The Panel therefore found it particularly surprising to see this practice extended to a few respite care patients, albeit frail, whose stay at the hospital was elective, that is to say planned and predominantly for a short period, and to patients admitted for rehabilitation.

- The Panel's analysis shows that over half of patients whose records were complete enough to assess were given a combination of three drugs via syringe driver: diamorphine, midazolam and hyoscine. There was little evidence that any consideration went into assessing what combination of drugs was best for an individual patient. Agitation and restlessness could have been managed with midazolam alone. The combination of all three drugs would cumulatively depress consciousness and respiration. Diamorphine itself can cause agitation. The majority of patients given the combination died on the same day or the next day.

- Diamorphine has approximately three times the potency of oral morphine. Accordingly, to maintain dose equivalence when making this switch, the dose of diamorphine should be one-third of the dose of oral morphine over a 24-hour period. This is spelled out in the relevant guidance, the British National Formulary.

- Despite the guidance, there is little evidence in the documents seen by the Panel to suggest that, when switching a patient from an oral opioid to a subcutaneous opioid, the conversion guidance was acknowledged and applied. In 72% of cases, the dose of subcutaneous diamorphine exceeded the equivalent dose at the time the switch was made.

- There is a pattern of deaths at the hospital, which shows a marked increase from 1993, peaking in 1998 and then decreasing sharply to resume the previous annual level by 2001. There is no evidence to support this being the result of a rise in the number of more seriously ill patients or those requiring end of life care.

- The available documents do not provide an explanation which would account for the high level of deaths recorded as due to bronchopneumonia, particularly as the underlying cause of death.

- The number of deaths ascribed to bronchopneumonia as the underlying cause followed the same pattern of increase and decrease over the 1990s as both the use of opioids without appropriate clinical indication and the number of deaths overall.

Chapter 3: The experience of patients and families on the wards

Introduction

3.1 The Panel's analysis in Chapter 2 has exposed the pattern of prescribing and administering opioids at Gosport War Memorial Hospital ('the hospital') and the deaths that resulted.

3.2 This chapter looks behind the statistics to the experience of patients and their relatives, how the drugs were given and how patients were treated by the nurses, the clinical assistant, the consultants and the pharmacists.

3.3 The Panel has had privileged access to the available medical records. While those records rightly cannot be published, this chapter uncovers what they say about what happened on the wards and draws upon a number of case studies and quotations from relatives to convey the reality for patients and their families. The case studies illustrate issues both in the drugs prescribed and administered and the wider standard of nursing care provided to patients at the hospital. Appendix 2 contains fuller versions of the summary case studies featured in this chapter.

3.4 This chapter discusses the respective roles and responsibilities of the nurses, the clinical assistant, the consultants and the pharmacists, and in so doing makes a number of points.

3.5 This chapter also considers the limited available information about communication at the time with the families of those patients who were treated on the wards. It is important to do so, not least to discount any suggestion that all of the families were consulted about and agreed to the drugs that were administered.

How the drugs were given

3.6 Chapter 2 has explained that opioids were prescribed with a wide range of dosage in a practice described as 'anticipatory prescribing'. Reinforcing the analysis from the data are eyewitness accounts of how the drugs were administered by nurses in accordance with this practice.

3.7 Pauline Spilka worked as a nursing auxiliary at the hospital from 1995 until 1999. At the time she made her statement in 2001, she had eight years' experience of caring for elderly patients within both the public and private sectors. Prior to working in the hospital, she was employed at the Acacia House Nursing Home in Horndean, Hampshire, as a night shift nursing auxiliary caring for elderly residents, and at the Greylingwell Hospital in Chichester, West Sussex, where she worked as a nursing auxiliary on an elderly mental health ward.

3.8 In April 2001, Pauline Spilka provided Hampshire Constabulary with a statement which included the following description of how patients were given the drugs:

> "Patients would arrive on the ward to be admitted by the clinical assistant or if she was not available then occasionally Dr LORD. If the patient was accompanied by relatives then a discussion would be held and a care plan would be drawn up; The care plan would involve other specialists such as the Physiotherapists, Occupational Health, Dieticians etc. Each patients care plan was included with their general notes and another of my functions would be to ensure that I knew what the care plan was in respect of each patient.
>
> It was some while later that I was to learn that all patients upon their admission were written up (by the doctor) who authorised the use of a syringe driver if appropriate. This enabled any member of the nursing staff to set up a syringe driver for a patient without any further reference to the doctor. Although I cannot be certain I think this was explained to me by the Staff Nurse … I am sure however that this was not common knowledge among the majority of the nursing auxiliaries.
>
> Despite my experience in elderly care I had never heard of a syringe driver prior to working at the War Memorial Hospital. I was later to learn that it was a device used for pain relief in seriously ill patients, the driver delivers a constant dosage over a period of time. It was also clear to me that any patient put onto a syringe driver would die shortly after. During the whole time I worked there I do not recall a single instance of a patient not dying having been put onto a driver.
>
> I have never received any training in respect of a syringe driver nor have I ever used one in order to administer drugs to any patient.
>
> The regime on the ward was as follows. If one of the trained members of nursing staff considered that a patient required the use of a syringe driver then they would seek the approval of another trained nurse. Having reached agreement then the driver would be set up. The needle would be inserted into the patients back so as to make it impossible for it to be removed.
>
> I have witnessed disagreements between nurses where one of them did not agree that a patient required the use of a syringe driver. These disagreements would be resolved by the nurse requiring the syringe driver approaching a more senior nurse and obtaining their consent. Once that consent had been obtained then the syringe driver would be set up.
>
> I have never known of a case where a staff member did not obtain permission to use a syringe driver from senior staff.
>
> I referred earlier to a particular case that troubled me deeply. The patients name was … He was aged about 80 and during 1997 or 1998 was a patient on the ward suffering from stomach cancer.
>
> [The patient] was quite a character who loved to eat sweets and crisps that had been brought in for him by friends and family. He would eat so many that the staff would sometimes have to confiscate them from him to stop him from being sick. Mentally he was alert and capable of long conversations I recall that he was in room 8B which is a ward for 4 patients all of whom spent many hours chatting together and watching TV.

If I am right, at the same time another of the other patients had been a professional footballer with Portsmouth and the patients would chat for hours about old matches.

Physically he was able to walk with the aid of a zimmer frame and was able to wash himself. It is important that patients are encouraged to continue with these tasks allowing themselves a level of independence and more importantly dignity. [The patient] however tended to be rather lazy in this respect and in many ways was quite a difficult patient. He liked to think of himself as being more ill than the other patients and seemed to quite enjoy the attention this brought. However he would sometimes get quite tearful about his condition.

I remember having a conversation with one of the other auxiliaries, Marion BERRY, we agreed that if he wasn't careful he would 'talk himself onto a syringe driver'. [The patient] although frail was not (in my opinion) near death at that time.

One day I left work after my shift and he was his normal self. Upon returning to work the following day I was shocked to find him on a syringe driver and unconscious …

I said 'Did you tell him he'd be dead at the end of this?'

[The nurse] said 'You know he's gone downhill we don't know how long he's got left'

I said 'That's not the issue did you tell him he'd be dead?'

[The nurse] was unable to answer me.

The previous evening [the patient] had been alert and perfectly capable of decision making and conversation I was concerned that the inevitable outcome if he succumbed to a syringe driver would be his death. I wanted to be reassured that he had been given a full explanation before allowing a syringe driver to be introduced. [The nurse] was unable to provide me with any reassurance. Knowing [the patient] as I did I am confident that he to would not have allowed the introduction of a syringe driver had he known of the outcome.

[The patient] subsequently remained unconscious until his death. He lasted some while. Whilst accepting that I have no medical qualification I am concerned that he was certainly not in imminent fear of death when he allowed the syringe driver to be introduced.

I know that there was considerable disquiet amongst both the nursing and auxiliary staff over [the patient].

After the syringe driver had been introduced I felt unable to discuss [the patient] with his family when they visited. Families often naturally seek reassurance from any member of staff when they visit. Things like 'How does he look to you?' I was so upset by the whole situation that I felt unable to face them until his death. I was worried that I would say something out of turn.

There was an atmosphere between [the nurse] and I which led to us speaking in his office on a couple of occasions over the following week. He accused me of 'Failing to come to terms with death'. This was ludicrous by then I had over 7 years experience in elderly care and had seen many many deaths. He failed to see my point that this death had been unnecessary.

> I cannot explain why I didn't speak out against the regime within the ward. I feel incredibly guilty about the death of …
>
> I can recall a patient being admitted onto the ward almost unconscious. She was an elderly Welsh lady. [A nurse] spoke to the family and explained that the lady was in pain and that all in all the syringe driver should be used to relieve her pain. The family were united in the belief that all medication should be stopped to see if that brought about a change in their mothers condition.
>
> The medication was withdrawn and over the next couple of days the lady improved beyond all recognition within a short time I remember walking arm in arm with her along the corridor having a conversation. She was subsequently discharged home to live with her daughter. I understand that she lived for a further year. This would certainly not have happened were the syringe driver set up upon her arrival." (HCO110756, pp1–3)

3.9 The Panel found nothing in any of the records, medical or otherwise, it has examined that would undermine Pauline Spilka's account. Her experience is confirmed by the case studies the Panel has prepared – these are intended to convey the experience of the patients as recorded in their medical records (without actually publishing those records). The Panel has considered issues concerned with the particular syringe drivers, known by their tradename of Graseby, and is aware of the Hazard Notices which applied. The Panel's analysis does not rest upon any issue relating to these notices.

3.10 Case Study 1 illustrates a pattern of prescribing and administering which quickly led to death. The patient, however, was being considered for placement back in a nursing home only days before her death.

Case Study 1 – Ethel Thurston summary

Patient story

In 1999, Ethel Thurston was aged 78 and lived in a nursing home. She had learning difficulties and was thought to have the mental capacity of a ten year old. Miss Thurston had once held down a job in a bank, was able to perform simple tasks and had been able to travel across London independently. She was long-sighted and wore glasses. Miss Thurston was said to have become aggressive from January 1999, and by June the nursing home was considering seeking a referral to a psychiatrist specialising in old age.

On 15 June, Miss Thurston fell and fractured her left neck of femur. She was admitted to the Royal Hospital Haslar ('Haslar Hospital'). She had a left cemented hemiarthroplasty (partial hip replacement). On 29 June, Miss Thurston was transferred to Gosport War Memorial Hospital ('the hospital') for rehabilitation and mobilisation where she remained until she died on 26 July.

Care received

Miss Thurston was assessed at Haslar Hospital by Dr Richard Ian Reid on 24 June 1999. He noted that she was *"pleasant and cooperative … able to move both legs without pain and … to attempt to stand … she did not appear to be in any pain … she had the physical potential to remobilise".* On 29 June, Miss Thurston was admitted to Gosport War Memorial Hospital for rehabilitation, care and mobilisation.

At the time of her admission to the hospital, Miss Thurston was able to wash, dress and feed herself with encouragement and some help. Although she had a limited vocabulary, she had no difficulty in communicating. In addition to her fractured femur, Miss Thurston had an ulcer on her lower left leg, was prone to constipation and had in recent years become incontinent, which had necessitated the use of a catheter at Haslar Hospital. Miss Thurston's drug therapy was oxybutynin (for urinary incontinence) and zopiclone (a night sedative).

On admission to the hospital, the nursing notes record Miss Thurston as demented with learning difficulties; in need of hoisting with *"no inclination to rehabilitate"*; very reluctant to take food and fluids; and *"willing to feed herself only if she feels like it"*. In addition, *"her behaviour can be aggressive and she has been known to strike staff".*

On 1 and 7 July, a fentanyl patch (25 micrograms) was prescribed by Dr Jane Barton, to be given every three days. A patch was administered on 1 July and then every three days. The last patch was applied on 25 July.

On 7 July, a five-day course of oral antibiotics was prescribed and administered.

On 8 July, Dr Victoria Banks, a psychiatrist specialising in old age, observed that Miss Thurston seemed to have dementia; however, she was less certain about whether she had depression. Dr Banks recommended that Miss Thurston's urinary catheter be removed and that she be treated with subcutaneous fluids and intravenous antibiotics. The nursing notes record that Dr Barton decided against intravenous antibiotics at that time.

On 16 July, Miss Thurston was noted to be *"much more settled"*. The plan at that stage was to transfer her back to the nursing home and, on 19 July, she was seen by Dr Reid who agreed with the plan for placement back in the nursing home. He noted that she had pain in her knees, was refusing oral analgesia and was *"better on fentanyl"*.

On 25 July, the care plan entries record that Miss Thurston was a *"little brighter"*. The clinical notes confirm that Dr Beasley saw Miss Thurston later that day and noted: *"Refusing all fluids and food … turned face to the wall … problems with constipation, refuses painkiller-fentanyl patches only can be used."* The nursing notes record that Miss Thurston's *"general condition seems to be deteriorating"*.

On 26 July, Dr Barton saw Miss Thurston. She made a brief note in the clinical records – *"further deterioration overall … please keep comfortable. I am happy for nursing staff to confirm death"* – and prescribed diamorphine 20–200 mg and midazolam 20–200 mg to be administered by 24-hour subcutaneous infusion as required. The following record was made in the nursing notes: *"Syringe driver started diamorphine 90mg. Midazolam 20mg."* The drug chart records that these doses were administered at 11:15. At 19:00, a nurse confirmed Miss Thurston's death.

Miss Thurston's death certificate recorded the cause of death as bronchopneumonia and senile dementia.

Panel comments

1 and 7 July 1999

- At the time of her transfer to the hospital, Miss Thurston was not in pain or receiving any analgesia.
- The Panel has not found any entries in the clinical notes for 1 and 7 July. The care plan entries for these dates are scanty.
- The Panel has not found any document in the clinical records to show that fentanyl was clinically indicated at any time.
- The Panel has not found any document in the clinical records to confirm Dr Barton's rationale for prescribing fentanyl on 1 and 7 July.
- The Panel has not seen any document to confirm that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines[1] to scrutinise the fentanyl prescription, or that they refused to administer the fentanyl patch at any time.
- It is not clear from the records why antibiotics were prescribed. The records indicate that this was related to the catheter and/or the urinary tract.
- The records indicate that Miss Thurston's catheter was not removed until 11 July, when it became blocked.

8 July 1999

- The Panel has not found any document to confirm the reason for Dr Barton's decision that intravenous antibiotics should not be commenced.
- The Panel notes that there was no facility at the hospital for administering drugs and fluids intravenously.

1 Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.

- The Panel has not found any record to confirm that Miss Thurston was treated with subcutaneous fluids.

19 to 24 July 1999

- The Panel has not seen any document in the medical records to confirm the cause or degree of pain in Miss Thurston's knees on 19 July.
- There are no entries in the clinical notes from 19 July until 25 July. The care plan entries for this period are scanty. The nature of Miss Thurston's condition during this period is not clear.

25 and 26 July 1999

- The Panel has not seen any document in the clinical records to confirm the nature and extent of Miss Thurston's deterioration on 26 July.
- It is not clear from the medical records why, on 26 July, Dr Barton requested nursing staff to keep Miss Thurston comfortable and why Dr Barton noted that she was *"happy for nursing staff to confirm death"* when Dr Reid had decided that Miss Thurston *"had the physical potential to remobilise"*. In addition, on 16 and 19 July, the plan was that she should return to a nursing home.
- The Panel has not seen any document in the clinical notes to confirm that nurses engaged in any adequate end of life care discussion with Miss Thurston's family.
- The Panel notes the prescribing of diamorphine and midazolam in high and very wide dose ranges on 26 July.
- The Panel has not found any document in the clinical records to show that diamorphine and midazolam were clinically indicated on 26 July.
- The Panel has not found any document in the clinical records to show that the fentanyl patch was removed at any point prior to the commencement of diamorphine. The Panel notes that if the fentanyl patch had been removed when diamorphine was commenced, a substantial amount of fentanyl would remain in the body and be clinically active for several days.
- The 90 milligram (mg) starting dose of diamorphine was excessive, at least three times the recommended dose equivalent when changing from a fentanyl patch to subcutaneous diamorphine.
- The Panel has not seen any document to show that nurses consulted the BNF guidance or the Wessex guidelines to scrutinise the doses of diamorphine and midazolam, questioned any of the consultants, doctors or the pharmacist at the hospital in respect of the prescription and doses, or refused to administer the diamorphine and midazolam.
- The Panel has not seen any document in the medical records to show the rationale for the decision to commence the diamorphine infusion at a dose of 90 mg over 24 hours on 26 July.
- The Panel has not seen any document in the medical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of diamorphine at 90 mg.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of diamorphine and midazolam or the choice of starting dose.

General comments

- Overall, the Panel found a lack of information in Miss Thurston's clinical notes. Entries were made on only 8 of the 28 days that Miss Thurston was in the hospital.
- The Panel found a lack of information in Miss Thurston's daily nursing notes and care plans. The nursing notes and care plans seen by the Panel were scanty, were not personalised to the patient's needs and contained missing entries for entire days. There was nothing in the care plans that took account of Miss Thurston's cognitive impairment, capabilities, likes, dislikes and preferences.
- The Panel found no pain charts or pain management plans in Miss Thurston's medical records. It is not clear to the Panel how Miss Thurston's pain and the effectiveness of any analgesia were adequately monitored.
- The Panel has not seen any nutrition or fluid charts among Miss Thurston's medical records. Fluid and nutritional intake is an important part of the clinical picture. Fentanyl, diamorphine and midazolam could impair Miss Thurston's ability to eat and drink.
- The Panel has not seen any document in the medical records to show that the nurses took into account the possible side effects of morphine when noting Miss Thurston's condition.

- The Panel has not found any document in the medical records to show any evidence of bronchopneumonia.
- The Panel has not found any document in the medical records to show that any discussion took place with Miss Thurston's family or carers about her treatment.
- Miss Thurston died approximately eight hours after the first, large and only dose of diamorphine.

3.11 A feature of Case Study 1, as it was of Pauline Spilka's statement and the nurses' concerns in 1991, is the insertion of a syringe driver. Figure 8 in Chapter 2 shows that following the introduction of three drugs – diamorphine, midazolam and hyoscine – particularly all three drugs together, death was inevitable, usually within a short period. For the patient in Case Study 1, that period was less than eight hours.

Two relatives told the Panel of their experience when they queried the morphine given to their mother:

> "On 13 August she was sent by the staff to the Queen Alexandra Hospital for a scan. There was no question of incapacity or chronic pain – indeed, we were asked if we could arrange to take her but this was not possible on that day. Without any consultation, on 20 August she was put on a regime of morphine and food and liquids were withdrawn. Within nine days she died – cause of death broncho-pneumonia. At one stage we suggested that the treatment was killing her but the doctor denied this, saying that that was 'your opinion'. Clearly there was something fundamentally wrong at the Gosport War Memorial Hospital."

How patients were treated: the roles and responsibilities of the nurses

3.12 As Chapter 2 and Case Study 1 show, the typical pattern was to provide for a wide dose range through anticipatory prescribing. While responsibility for the prescribing lay with the clinical assistant or the consultants, the typical pattern left two major decisions to the nurses on the ward: when to start the medication and syringe driver, and what dose to administer within the range prescribed. In Case Study 1, the nursing notes show that the sister recorded diamorphine started at 90 mg when Dr Jane Barton, the clinical assistant, had prescribed 20–200 mg. At the time of prescribing, Dr Barton is recorded as saying, as in other cases seen by the Panel: *"I am happy for nursing staff to confirm death"* (SOH900234, p27).

3.13 Chapter 1 has shown that members of the nursing team were the first to draw attention to problems with the pattern of prescribing and the administration of drugs by continuous subcutaneous infusion (that is, through syringe drivers). However, the records also show that nurses in the hospital administered the drugs and continued to do so for many years, although the link with the pattern of deaths would have been apparent to them. Within the professional standards which applied at the time, the nursing staff also had a responsibility to intervene and challenge the prevailing practice on the wards.

A niece recalled her experience of finding her aunt on the ward:

> "When we visited we found her sitting on a bean bag at floor level, unable to move if she had wanted to. On our last visit she was in a cot, a nurse was administering morphine and said it was 'unusual for someone to take this amount'. We thought at the time that my aunt was distressed as she was wriggling about and moaning. The nurse did not seem unduly worried."

3.14 The Panel has seen accounts from the nurses about the part they played in administering prescribed drugs. For example:

> "Administration of medication as a result of such a prescription was not automatic. If, for example, Diamorphine was to be administered via syringe driver the Nursing Staff would assess the patient first, and it would only be given if necessary. Two nurses would be involved in the process. Similarly, if medication was being increased on the basis of such a prescription, again it would only be following an assessment by Nurses, and where it was necessary to increase it. I felt we had knowledge and experience as Nurses to judge properly when patients were in pain and required appropriate medication … Dr Barton would though learn of what had taken place when she next attended at the Hospital – usually the following morning." (MDU000002, p4)

3.15 The Panel has found no evidence of the nurses routinely acting to avoid the problem identified in Finding Four in Chapter 2: the escalation of dosage which occurs when changing from an oral to a subcutaneous opioid if the same dose is maintained. The practice of anticipatory prescribing compounded this risk and relied upon the nurses' understanding of dose equivalents when changing from oral to subcutaneous administration.

3.16 Beyond the administering of drugs, the Panel found an overall picture of nursing care which requires comment, even when assessed against the standards prevailing at the time. Case Studies 2 and 3 illustrate the wide-ranging issues which the Panel's research has identified more generally at the hospital and the fuller versions of these case studies are therefore included in this chapter. In order to understand the full significance of the picture which emerges, it is necessary to recall the professional standards which applied at the time.

3.17 The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) published *The Code of Professional Conduct for Nurses, Midwives and Health Visitors* in 1992. The Code sets out very clear expectations of how registered nurses should conduct themselves in their role, and the skills and knowledge expected by the profession. All registered nurses are required to maintain themselves on the professional nursing register. The Code makes clear their responsibility for public safety, advocacy for the patient, and the right to challenge and seek redress when they disagree with the actions of others, including medical staff, that they consider to be not in the best interests of the patient. Specifically, the 1992 Code provides that:

> "As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in exercise of your professional accountability must:
>
> - Ensure that no action or omission on your part, or within your sphere of responsibility is detrimental to the interests, condition or safety of patients/ clients

- Maintain and improve your professional knowledge and competence
- Acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner
- Work in an open and co-operative manner with patients, clients and their families, foster independence and recognise and respect their involvement in their planning and delivery of care
- Work in a collaborative and co-operative manner with health care professionals and others involved in providing care, and recognise and respect their particular contributions within the care team." (HCO005169, p49)

3.18 The UKCC *Standards for the Administration of Medicines*, also published in 1992, are clear in establishing the principle that administering drugs:

"… is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner. It requires thought and the exercise of professional judgement that is directed to:

Confirming the correctness of the prescription

Judging the suitability of administration at the scheduled time of administration

Reinforcing the positive effect of the treatment

Enhancing the understanding of patients in respect of their prescribed medication and the avoidance of misuse of these and other medicines.

Assisting in assessing the efficacy of medicines and the identification of side effects and interactions." (HCO003779, p10)

3.19 The Standards also establish the principle that *"as a registered nurse, midwife or health visitor you are personally accountable for your practice"*. In exercising their professional accountability, nurses must:

"• Act always in a manner to promote and safeguard the interests and well-being of patients and clients
- Ensure that no action or omission on your part. Or within your sphere of responsibility, is detrimental to the interests, conditions or safety of patients and clients
- Maintain and improve your professional knowledge and competence
- Acknowledge any limitations in your knowledge and competence and decline duties or responsibilities unless able to perform them in a safe and skilled manner."

3.20 Section 8 of the 1992 Standards provides explicitly that a nurse *"must, in administering, assisting or overseeing and self-administration, exercise professional judgement and apply knowledge and skill to the situation that pertains at the time"*.

3.21 The importance of timely and accurate record keeping for nurses has also been established, for example in the Nursing and Midwifery Council (NMC – the successor organisation to the UKCC) *Guidelines for records and record keeping*, 1998. This provides that records should:

> "• Be written, wherever possible, with the involvement of the patient or client or their carer …
>
> • Identify problems that have arisen and the action taken to rectify them
>
> • Provide clear evidence of care planned, the decisions made, the care delivered and the information shared."

3.22 A registered nurse would have both a professional and a legal duty of care. Their record keeping should therefore be able to demonstrate:

> "• A full account of their assessment and the care planned and provided
>
> • Relevant information about the condition of the patient or client at any given time and the measures taken to respond to patients' needs
>
> • Evidence that the nurse has understood and honoured their duty of care, has taken all reasonable steps to care for their patients and that any actions or omissions have not compromised patient safety in any way."

3.23 To complement the Standards, from the early 1990s there were clear expectations from the UKCC and the Department of Health that nurses should be committed to lifelong learning and continuous professional development. Nurses were required to continually update and improve their practice through personal and professional development.

3.24 The Panel has been unable to find records of training in clinical and other expected learning programmes. It is therefore unclear how the nursing staff at the hospital were supported in keeping up to date with contemporary practice and expectations for the care they were expected to deliver.

3.25 The Panel has not applied a standard of perfection when comparing what the records show happened at the hospital with the formal standards and expectations. It has also borne in mind that nursing staff should not have been put in the position of being the sole arbiters of when to start continuous opioids and what doses to employ, particularly in the absence of adequate training. However, the Panel found a picture of care which fell well below the expected standards of nursing practice at that time. It is a picture which demonstrates a lack of concern and regard for individuals' assessed needs, as well as a lack of challenge to the prevailing prescribing practice at the hospital. It also illustrates the bravery of the nurses who raised concerns in 1991 (see Chapter 1).

3.26 The Panel found a lack of patient-centred care, in both planning and responding to changes in the condition of patients in the nurses' care. The standard of assessment was inadequate, scanty and missed key information that ought to have been reflected in individual care plans. The Panel found no evidence in the nursing notes to suggest that nurses were using pain assessments to inform decisions about the need for drugs to reduce or manage pain; or the required dosage. Nor did the nurses appear to be assessing the effects of those drugs. References in the nursing notes to patients being *"unresponsive"* are a poor substitute for the standard of assessment which should have been in place.

3.27 Record keeping was inadequate and did not meet the expected standards of professional guidance as set out at that time. Nursing assessment records were incomplete or absent, or recorded no data in patients who clearly had needs; they also failed to record the clinical justification for starting continuous opioid medication.

3.28 There was no evident monitoring of the effect of medication in most cases. In the clinical notes, the Panel found inadequate statements such as *"appears to be in pain"* or *"distressed when turning"*. These loose descriptions in themselves expose a picture of poor understanding of pain management and poor use of appropriate scales when assessing both verbal and non-verbal responses to pain.

3.29 The Panel was concerned about the reliance on nurses alone to make key decisions about such significant medication. There is very little evidence in nursing notes that discussions took place about dose and type of medication, or to show that there was communication within the team. The impression given is of a prevailing culture dominated by the clinical assistant and the consultants which overshadowed any understanding that the nurses could or should exercise their autonomous professional status.

3.30 The shortcomings in nursing care extended to passive and inappropriate responses to the needs of patients, particularly at key times such as at hospital admission. This was particularly evident in patients who had fallen, patients who had expressed distress, and patients who were agitated.

3.31 The Panel found some clinical records showing obvious changes, such as distressed behaviour, changed responses and clinical deterioration, that were not reflected in revised care plans. This suggests a lack of continuity between shift teams when handing over problems. The care plans illustrate a task-orientated and perfunctory approach to care, custodial in their approach with little reference to the individual.

3.32 Nor do the records show any planning for end of life care, including for appropriate contact with the family. The absence of any reference to the psychological needs of individuals, or discussion about their condition, anxieties and fears, suggest a lack of awareness of end of life care, a lack of regard for individual wishes, needs or concerns and a failure to provide an opportunity for patients to express their worries.

3.33 The records show that common practice at the hospital was to anticipate the patient's death when prescribing the drugs. This is clearly shown by repeated entries in the clinical notes saying (as in Case Study 1) *"I am happy for nursing staff to confirm death".* This meant that the doctor had delegated authority to the nurse to establish death. The deceased could then be moved from the ward instead of waiting until a doctor was available to externally examine the body in person. The verification of death by nurses is not in itself a concern, though the Panel notes that the practice did not conform with the hospital's policy at the time: this required two nurses to be involved in the verification procedure. However, the repeated pattern of a direct link between the appearance of this statement (as well as *"please make comfortable"*) in clinical records with the prescribing of continuous opioids and the deaths which shortly followed is noted.

3.34 This range of shortcomings in the care provided at the hospital, coupled with the prevailing prescribing practice, is evident in a number of case studies examined by the Panel. Two such case studies are included here in full. Case Study 2 illustrates poor record keeping as well as a failure to respond to the patient's needs, a failure to correct the misdiagnosis of a fracture and the commencement of diamorphine, hyoscine and midazolam at high dosage. The patient

in this case study is recorded as dying 30 minutes later. Case Study 3 shows no evidence that nurses engaged in any adequate ongoing treatment or end of life care discussion with the patient's family. As with other cases, the Panel found a lack of detail in the patient's daily nursing notes and care plan. The care plan for this patient lacked entries for 19 of the days that the patient was admitted. There was nothing in the care plan which took account of the patient's capabilities, likes, dislikes or preferences.

Case Study 2 – Wilfred Harrington

Summary of hospital admission

- In 1993, Wilfred Harrington was aged 88 and lived at home with his wife who provided him with full-time care.
- On 8 June 1993, Mr Harrington was admitted to Gosport War Memorial Hospital ('the hospital') for a two- to three-week period of rehabilitation and respite care.
- On 21 June, Mr Harrington was assessed by a physiotherapist, when he stood from his chair and walked 15 yards with a Zimmer frame and assistance. His admission was extended for a further two weeks.
- On 5 July, Mr Harrington was not mobile, needed a hoist for transfer and had lost one and a half stone. His admission was changed to a long stay.
- On 21 July, Mr Harrington died.

Background, care and treatment

In 1993, Mr Harrington was living at home with his wife. He had congestive heart failure, a sacral sore and blistering on his legs and toes. He required care and assistance from his wife when washing, dressing and walking with his Zimmer frame. He had been experiencing a reduced appetite and some weight loss because his top teeth had been removed, making it difficult to chew his food.

On 3 June 1993, Dr Althea Lord assessed Mr Harrington in outpatients and wrote a letter to his GP, saying:

> "… he is feeling weak and unable to stand mainly due to blistering on his legs … He is dependent on [his wife] for washing and dressing, needs her help to mobilise … and could be incontinent … on occasion. [He] still had an element of congestive heart failure with a large sacral pad. His sacrum was red and the skin was split in the natal cleft. His pulse was 80 a minute and regular … He had bilateral basal crackles. I felt [Mr Harrington] needed an admission in order to see if his congestive cardiac failure could be improved as his leg blisters may well then subside. His mobility could be improved and [his wife] could have a break as well."

Dr Lord also noted Mr Harrington's current medication to be frusemide, digoxin and enalapril.

On 8 June, Mr Harrington was admitted to Daedalus Ward at the hospital for a two- to three-week period of rehabilitation and respite care.

On admission, Dr Jane Barton recorded in the clinical notes: *"Admission for respite care. Recent difficulty coping at home … Feeds himself, needs help with dressing … can't wash unaided, blistering of legs and foot."* The medical records confirm that Mr Harrington was taking co-proxamol, although it is not clear precisely why this analgesic was prescribed. He required assistance with washing and dressing and had poor balance. He had a poor appetite and a tendency to suffer constipation and urinary incontinence. He also had blisters on both legs, and required assistance to settle at night. Mr Harrington was unsteady on his feet but could walk short distances with a Zimmer frame.

On 9 June, the nursing notes record: *"Night. Very confused, fell out of bed 23.10 hours. Sustained grazing to both knees, dressing applied to left knee no further signs of injury visible. Accident form completed."*

On 16 June, the nursing notes record *"skin flap observed at 3am, steristrips and dressing and bandage applied, accident form filled in"*.

Panel comments

- The Panel has found no entries in the clinical notes after 8 June, until 17 June. The medical records indicate that Mr Harrington was not seen by any doctor during this period.

- On 9 June, Mr Harrington fell out of bed with no injury noted, and on 16 June injury requiring steristrips and a dressing occurred. The Panel has found no other details relating to the fall or injury in the nursing notes.

On 17 June, Dr Lord recorded in the clinical notes: *"CCF not under control … daily [weights], U/Es Monday. See legs Monday."* Dr Barton requested that Mr Harrington be seen by the physiotherapist for *"gentle mobilisation"*.

On 20 June, the nursing notes record *"catheterised"*.

On 21 June, Dr Lord recorded in the clinical notes *"catheter inserted … blisters now dry, grazed both knees, not stable, confused at night, Barthel 6. OT [occupational therapist] to see … to stay in further 2/52 [2 weeks]."* Mr Harrington was also seen by the physiotherapist, who wrote in the clinical notes: *"[Mr Harrington] stood from his chair unassisted but needed steadying when standing. He walked with his Zimmer frame about 15 yds but tired and stiff his legs giving way. He would not be safe to walk unaccompanied and the moment."*

On 25 June, Dr Barton recorded in the clinical notes that Mr Harrington *"has become poorly over the last four hours, weak, confused and swollen penis [illegible], basal creps, needs metolazone today. U's and E's this pm deterioration in renal function".* Dr Barton prescribed morphine oral solution 10 mg (5 ml) every six hours *"if in pain".* However, this prescription was not administered.

Panel comments

- The Panel has found no document in the medical records to confirm Dr Barton's rationale for prescribing morphine oral solution on 25 June.

On 28 June, the nursing notes record: *"not so well this morning … has back pain. [Seen by] Dr Barton left leg and foot inflamed. Commenced antibiotics and Co-Dydramol for pain. To continue to record daily weight if well enough."*

Dr Barton prescribed co-dydramol every six hours. This prescription was administered once on 28 June at 09:15, and twice on 2 July at 13:30 and 18:00.

On 3 July, the nursing notes record that Mr Harrington fell out of bed with no apparent injuries noted. One dose of co-dydramol was administered at 09:00.

Panel comments

- The Panel has found no further details relating to the fall on 3 July.
- The Panel has found no entries in the clinical notes after 25 June, until 5 July.

On 5 July, Dr Lord recorded in the clinical notes that Mr Harrington was not mobile, needed a hoist for transfer and had lost one and a half stone between 10 June and 5 July. The next day, Mr Harrington's wife agreed to a long-stay bed.

Panel comments

- The Panel has found no document in the medical records to confirm why Mr Harrington had become immobile by 5 July.
- Save for one entry on 6 July to confirm Mr Harrington's wife's agreement to a long stay, the Panel has found no entries other than bowel records and recordings of dressing changes in the clinical notes after 5 July, until 20 July. The medical records indicate that Mr Harrington was not seen by any doctor during this period.
- The nursing care plans indicate that during this period the nursing staff continued to monitor and treat Mr Harrington's sacral sore, elbow, grazed knees, constipation, catheter and blisters on the legs, which were noted to be healing well on 13 and 21 July. Regular weight loss monitoring effectively ended on 5 July, with one further entry on 13 July of nine stone. Assistance with washing and dressing continued until 9 July when the notes record that thereafter Mr Harrington required bed baths.
- The Panel has not found any record to confirm why nursing staff stopped monitoring Mr Harrington's weight.

On 19 July, Dr Barton prescribed morphine oral solution 10 mg (5 ml) every six hours *"if in pain"*, and co-dydramol every six hours.

Panel comments

- The Panel has found no document in the medical records to confirm Dr Barton's rationale for prescribing morphine oral solution on 19 July.

On 20 July, the next entries appear in the nursing notes and care plans. The nursing notes record *"contracted and painful left leg"* and *"seen by Dr Barton X-ray of right hip requested".* The care plans record *"unable to tolerate any attention to arms or legs".*

At 16:30, the nursing notes further record *"X-ray shows fracture of the right femur. Dr Barton and Dr Lord discussed. Both agree patient too ill for operation. To have [morphine oral solution] 20mg orally and bed rest".* Between 11:25 and 23:45, three separate doses of morphine oral solution – 10 mg, 20 mg and 20 mg – and one dose of co-dydramol were administered to Mr Harrington.

Panel comments

- The medical records indicate that, prior to 5 July, Mr Harrington had been, to some extent, mobile. He had walked with a Zimmer frame and assistance, and was washing and dressing himself with assistance on a daily basis. The Panel has not found any document in the medical records to confirm the basis and rationale for the decision on 20 July that Mr Harrington was not fit for surgery.

On 21 July, the radiology report stated: *"PELVIS:… No fracture. No significant degenerative change for age is present and the remainder of the bony pelvis is normal … CHEST: … heart is not significantly enlarged and no gross pulmonary abnormality is shown."*

Panel comments

- Given the content of the radiology report, it is not clear on what basis Dr Lord and Dr Barton reached a misdiagnosis that Mr Harrington had fractured his right femur the previous day; nor is it clear from the clinical notes whether Dr Barton or Dr Lord were aware of the radiology report on 21 July.
- The Panel has not seen any record of any further review by Dr Lord.

On 21 July, the nursing notes record *"painful on moving may require analgesia later today".* Morphine oral solution 20 mg was administered at 06:10. His prescribed oral drugs were omitted at 08:00 as he was unrousable.

Dr Barton recorded in the clinical notes: *"Developed contractures of arm and legs this week. Severe pain in hip yesterday. X-ray [illegible]. Condition continues to deteriorate. For sc analgesia. All nursing care."*

The drug chart confirms that Dr Barton prescribed a subcutaneous infusion of diamorphine 40 mg, hyoscine 200 micrograms and midazolam 20 mg per 24 hours.

The nursing notes also record: *"X-ray report … no fracture. Seen by Dr Barton to commence syringe driver for pain and chestiness. Becoming increasingly breathless. Syringe driver set up at 14.30 hours".*

A syringe driver containing diamorphine prescribed at a rate of 40 mg per 24 hours, hyoscine at 200 micrograms per 24 hours, and midazolam at 20 mg per 24 hours was commenced.

Panel comments

- The Panel has seen no documents in the medical records to confirm why Mr Harrington had developed contractures. The Panel observes that there are no entries in the clinical notes after 5 July, until 21 July.
- The Panel notes that there was a misdiagnosis of a fracture on 20 July, which appears to have led to the initiation of the use of opioid analgesic. The Panel has not seen any document in the medical records to confirm that following the result of the X-ray Mr Harrington's assumed fracture was clinically reviewed.
- The nature and extent of Mr Harrington's *"chestiness"* and breathlessness noted on 21 July is not clear from the medical records. There is no cardiac or gross pulmonary abnormality reported on the chest X-ray on 21 July.
- The Panel has not seen any document in the medical records that gives any explanation for the nature, location and degree of pain noted on 21 July.
- The Panel has not found any document in the medical records to show that diamorphine, midazolam and hyoscine were clinically indicated on 21 July.
- The Panel has not found any document in the medical records to confirm Dr Barton's rationale for prescribing diamorphine, midazolam and hyoscine on 21 July.

- The Panel notes the prescribing of diamorphine, hyoscine and midazolam in high doses. The dose of diamorphine administered on 21 July was approximately double the equivalent dose of morphine oral solution. No consideration was given to the fact that Mr Harrington was unrousable two hours after the dose of oral morphine on 21 July.
- At the time of Mr Harrington's admission, accountability was an integral part of nursing practice. Nurses were accountable for their actions, and inactions, at all times. The relevant nursing professional codes of conduct and standards required nurses to: scrutinise a prescription in the interests of safety; question any ambiguity in the prescription; refuse to administer a prescription where they believed such an action was necessary; and report to an appropriate person or authority any circumstances that could jeopardise the standards of practice or any concern about health services within their employing Health Authority or Trust. The codes and guidance made it clear that to silently tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and contrary to personal professional accountability. Nurses were required to promote and protect the interests of patients.
- The Panel has not seen any document to confirm that the nurses consulted the British National Formulary (BNF) guidance or Wessex guidelines[2] to scrutinise the diamorphine, hyoscine and midazolam prescription or refused to administer the drugs at any time.
- The relevant nursing codes of conduct and standards required nurses to be able to justify any actions taken and to be accountable for the actions taken when administering or overseeing the administration of drugs. The Panel has not seen any document in the medical records that shows the nurses' rationale for commencing the prescription of diamorphine, hyoscine and midazolam.
- The Panel has not seen any document to show that the nurses were provided with any written guidance from the doctors, consultants or the Trust about when to commence the administration of diamorphine, hyoscine and midazolam.

The next entry on 21 July records that Mr Harrington's condition deteriorated rapidly and he died at 15:00.

Panel comments

- Mr Harrington died 30 minutes after the first and only dose of diamorphine, midazolam and hyoscine.
- At the time of Mr Harrington's admission, guidance from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) (see Bibliography in Appendix 2) emphasised the requirement for nurses to work in an open and cooperative manner with patients and their families. In this regard, the Panel has seen no documents in the clinical records to confirm that nurses engaged in any adequate ongoing treatment or end of life care discussion with Mr Harrington's family.
- At the time of Mr Harrington's admission, the UKCC guidance required nurses to carry out a comprehensive assessment of the patient's nursing requirements, and devise, implement and keep under review care plans. The UKCC guidance also required nurses to create and maintain medical records in order to provide accurate, current, comprehensive and concise information concerning the condition and care of the patient. Such records would include: details of observations, problems, evidence of care required, action taken, intervention by practitioners, patient responses, factors that appeared to affect the patient, the chronology of events, and reasons for any decision. These records would provide a baseline against which improvement or deterioration could be judged. Among other elements of care, *"Through their role in drug administration nurses are in an ideal position to monitor the drugs progress, reporting responses and side effects".* In this regard, the Panel found a lack of detail in Mr Harrington's daily nursing notes and care plans. The nursing notes and care plans seen by the Panel were scanty, lacked biographical data, were not personalised to the patient's needs and contained missing entries for entire days. For example, the 'Assistance to Settle at Night' care plan lacked entries for 28 of the days that Mr Harrington was admitted. There was nothing in the care plans to document Mr Harrington's confusion, to take account of his capabilities, or to identify his likes, dislikes and preferences. The Panel has found no pain charts or pain management plans in Mr Harrington's medical records. It is not clear to the Panel how Mr Harrington's pain and the effectiveness of any analgesia was adequately monitored.
- The Panel has not seen any nutrition or fluid charts among Mr Harrington's medical records. Fluid and nutritional intake is an important part of the clinical picture.
- Overall, the Panel found a lack of detail in Mr Harrington's clinical and nursing notes.

2 Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.

Case Study 3 – Peggy Coates

Summary of hospital admission

- In 1999, Peggy Coates was aged 76 and lived at home with her son.
- On 3 April 1999, she had a cerebral infarct (stroke) and was admitted to Queen Alexandra Hospital.
- On 2 June, she was admitted to Daedalus Ward at Gosport War Memorial Hospital ('the hospital') for rehabilitation and intensive nursing input.
- On 15 July, Mrs Coates died.

Background care and treatment

In 1999, Mrs Coates lived at home with her son. Her husband had recently died. She had a history of hypertension, heart failure, osteoporosis and non-insulin dependent diabetes mellitus which was controlled by tablets and diet. She also had depression. Her stroke had been complicated by epileptic fits.

On 2 June 1999, Mrs Coates was transferred from Queen Alexandra Hospital to Daedalus Ward at Gosport War Memorial Hospital. The records confirm that on transfer she had a diabetic diet and was able to feed herself. She wore pads for double incontinence, was immobile and required two people to transfer her from her bed to a chair. She was put into bed by hoist. Mrs Coates was also described as having confusion at times and experiencing a great deal of back pain. There had been variable success in controlling her pain and her diabetes was unstable. The only analgesia prescribed by Queen Alexandra Hospital was paracetamol. The initial plan was for Mrs Coates to return home, supported by her family. However, she was admitted to Daedalus Ward for rehabilitation and intensive nursing input.

On admission, Mrs Coates was assessed by Dr Jane Barton, clinical assistant, who noted: *"Please make comfortable … I am happy for my staff to confirm death."* The nursing notes record: *"slightly confused no hearing aid. Pt is compliant. Not in pain at the moment."* Dr Barton prescribed paracetamol 500 mg.

Panel comments

- It is not clear to the Panel why Dr Barton noted on Mrs Coates's admission to the hospital: *"Please make comfortable"* and *"I am happy for my staff to confirm death".* According to the records, the plan was that Mrs Coates would be rehabilitated and return home.

On 3 June, Dr Barton noted: *"had a brief convulsion this am … seems brighter now."* The nursing notes record: *"Dr Barton to commence … catheterisation if [Mrs Coates] agrees."* Later that day, Mrs Coates was catheterised.

On 4 June, the nursing notes record: *"fit after having a bath. Last for approx. 30 seconds. Limbs shaking recovered well remained in bed."*

On 5 June, the nursing notes record: *"not so well this morning. Son seen care discussed appreciates that condition may worsen."*

On 7 June, Dr Barton noted *"epilepsy -2 seizures since admission"* and prescribed morphine oral solution 10 mg in 5 ml (2.5–5 ml), four hourly, as required, and diamorphine 20–200 mg, hyoscine 200–800 micrograms and midazolam 20–80 mg all to be administered subcutaneously over 24 hours. The drugs were not administered. The nursing care plan records: *"2 paracetamol given for a headache prior to bedtime. Pt settled and slept well. Has woken up with a headache. Declined analgesia until after breakfast."*

Panel comments

- The Panel has found no document in the clinical records to confirm Dr Barton's rationale for prescribing morphine oral solution and the subcutaneous infusion of diamorphine, midazolam and hyoscine on 7 June.

On 13 June, the nursing care plan notes record *"generalised pain analgesia given".* The drug chart confirms that between 11 and 20 June, co-codamol was administered four times daily, and twice on 21 June.

On 18 June, the nursing notes record: *"22.20 requested Dr Briggs review pain relief due to headaches, neck aches and general discomfort."* On the same day, the clinical notes record: *"persistent headaches and muscoskeletal pain. Little benefit from the use of Co-codamol. Try small starter dose of oral morphine solution 5mg/10mls."* Dr Michael Brigg prescribed morphine oral solution 2.5–5 mg (2.5–5 ml) four to six hourly, as required.

On 20 June, morphine oral solution 5 mg (2.5 ml) was administered at 18:15.

On 21 June, the clinical notes record: *"headaches … complains of pain in both LLs calling out frequently."* The nursing notes record: *"seen by Dr Lord commence Co-dydramol, Amitriptyline and lactulose. Bowels to be observed."* Dr Barton prescribed morphine oral solution 10 mg/5 ml, 2.5–5 mg four hourly as required, and diamorphine, hyoscine and midazolam subcutaneously over 24 hours. In addition she prescribed co-dydramol six hourly.

Co-dydramol was administered between 21 June and 2 July.

On 28 June, Dr Althea Lord, a consultant geriatrician, recorded in the clinical notes: *"today pain in abdomen and back … oral morphine solution if very distressed."* The nursing care plan records: *"03.25hrs administered 5mg/2.5mls of oral morphine solution due to patient awake distressed and informing staff of pain in left shoulder. Pt wished for analgesia. 07.15 no pain on movement this morning."* Morphine oral solution 5 mg was also administered at 16:00.

On 29 June, morphine oral solution 5 mg was administered at 03:25 and 14:30.

On 2 July, the drug chart indicates that Dr Barton prescribed morphine oral solution 5 mg (2.5 ml) four hourly between 06:00 and 18:00 and one dose of morphine oral solution 10 mg (5 ml) to be taken at 22:00. The drug chart further indicates that these doses were administered to Mrs Coates daily between 3 and 4 July.

On 5 July, the drug chart indicates that 5 mg (2.5 ml) of morphine oral solution was administered at 06:00. The clinical notes record that Mrs Coates was reviewed by Dr Lord, who noted *"had some oral morphine solution over the w/e. Confusion. Varying sites of pain head and abdo … plan: try paracetamol for pain. Stop oral morphine solution."* The nursing notes record: *"unaware when being attended not safe to give oral medication. Comfortable and appears pain free. General condition deteriorated over-night."*

Panel comments

- The Panel has not found any document in the clinical records to show that morphine oral solution was clinically indicated between 2 and 5 July.

On 6 July, the nursing notes record: *"refused analgesia at 22:00 … headache this morning paracetamol given 06:55."*

On 9 July, the clinical notes record that Mrs Coates was assessed by Dr Barton, who noted *"not too well … urine cloudy suggests UTI start amoxicillin. pain relief still a problem try transdermal."* The drug chart records that Dr Barton wrote a prescription for a fentanyl patch 25 mg, at 10:00 every three days, which was administered on 9 and 12 July and remained in place until 14 July.

Panel comments

- The Panel has not found any document in the medical records to confirm Dr Barton's rationale for prescribing fentanyl on 9 July.
- The Panel has not found any document in the medical records to show that fentanyl was clinically indicated between 9 and 14 July.

On 12 July, the clinical notes record that Mrs Coates was reviewed by Dr Lord, who noted: *"more settled on fentanyl. Not calling out. Not distressed … drinking … not stable enough for D just yet."* The nursing notes record: *"Dr Lord, to continue with fentanyl patch."*

Panel comments

- It is not clear to the Panel what Dr Lord meant by *"not stable enough for D just yet".*

The nursing care plan notes that Mrs Coates had eaten small amounts daily from the date of admission up to 13 July.

On the night of 13 July, the night staff were concerned about Mrs Coates, who had deteriorated and was in pain on movement. They called in the family and agreed to the commencement of a syringe driver. The pre-prescribed (from 21 June) syringe driver containing diamorphine 20 mg, midazolam 20 mg and hyoscine 400 micrograms over 24 hours was commenced at 07:45.

On 14 July, an untimed note from Dr Barton records: *"marked deterioration during the day yesterday. Unrousable, [illegible], Cheyne-Stokes breathing overnight. SC analgesia started this am … I am happy for my staff to confirm death."*

The nursing notes record a further conversation with the family:

> "… son concerned that [Mrs Coates] not having any fluid. Reassured that we wish to keep patient pain free and this will render her unable to take oral fluids but we will be giving mouth care … family wanted to know if [Mrs Coates] could be given intravenous fluid advised by myself that this is not an option at this hospital and that patient would need transferring to another hospital. Family agreed that it would not be in patient's best interests due to very poor condition at present."

Panel comments

- The Panel notes that the clinical records appear to show the initiation of a diamorphine infusion in a patient with Cheyne–Stokes breathing.
- Cheyne–Stokes breathing is an abnormal breathing pattern which can be seen with opioid toxicity. The Panel notes that it might have been related to the use of the fentanyl patch.
- An alternative, because Dr Barton's entry is untimed and the Panel has been unable to find any record of Cheyne–Stokes breathing in the nursing notes, is that the patient had Cheyne–Stokes breathing when reviewed by Dr Barton and that this was due to the additional subcutaneous diamorphine being administered at an excessive dose.
- It is not clear whether the fentanyl patch was removed before diamorphine was commenced on 14 July. There is no record to show that it was removed. Even if it had been, it would still have been pharmacologically active.
- The Panel has not found any document in the clinical records to show that diamorphine, midazolam and hyoscine were all clinically indicated on 14 July. The Panel notes that Mrs Coates was described on 13 July as *"more settled on Fentanyl. Not calling out"* and on 14 July as being *"unrousable"* and having Cheyne–Stokes breathing.
- The Panel has not found any document to show the rationale for commencing a subcutaneous infusion of diamorphine, midazolam and hyoscine on 14 July.

On 15 July, doses for each of the components of the syringe driver medication were doubled. At 09:15, a syringe driver containing diamorphine 40 mg, midazolam 40 mg and hyoscine 800 micrograms was commenced.

Panel comments

- The Panel has found no document to confirm the rationale for the administration and doubling of the dose of diamorphine, midazolam and hyoscine on 15 July.
- The Panel has not seen any document in the medical records to confirm that diamorphine, midazolam and hyoscine were clinically indicated on 15 July.

Mrs Coates died on 15 July at 17:30.

Panel comments

- The Panel notes that Mrs Coates died the day after the first and high dose of diamorphine.
- Paracetamol, co-codamol and co-dydramol were used initially and then variously until 9 July. A 'starter dose' of morphine oral solution was prescribed on 18 June. Morphine oral solution was variously administered between 18 June and 9 July. On 9 July, fentanyl was prescribed and used until 14 July. On 14 July, subcutaneous diamorphine, midazolam and hyoscine were then introduced and used until Mrs Coates's death on 15 July.
- At the time of Mrs Coates's admission, accountability was an integral part of nursing practice. Nurses were accountable for their actions, and inactions, at all times. The relevant nursing professional codes of conduct and standards required nurses to scrutinise a prescription in the interests of safety, question any ambiguity in the prescription, where believed necessary refuse to administer a prescription, and report to an appropriate person or authority any circumstances that could jeopardise the standards of practice or any concern about health services within their employing Health Authority or Trust. The codes and guidance made it clear that to silently tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and contrary to personal professional accountability. Nurses were required to promote and protect the interests of patients.

- The Panel has not seen any document to confirm that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines[3] to scrutinise the morphine oral solution, fentanyl, diamorphine, hyoscine and midazolam prescription or refused to administer the drugs at any time.
- The relevant nursing codes of conduct and standards required nurses to be able to justify any actions taken and to be accountable for the actions taken when administering or overseeing the administration of drugs. The Panel has not seen any document in the medical records to show the nurses' rationale for commencing the prescription of morphine oral solution, fentanyl, diamorphine, hyoscine or midazolam.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of morphine oral solution, fentanyl, diamorphine, hyoscine or midazolam.
- At the time of Mrs Coates's admission, guidance from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) (see Bibliography in Appendix 2) emphasised the requirement for nurses to work in an open and cooperative manner with patients and their families. In this regard, the Panel has seen no documents in the clinical records to confirm that nurses engaged in any adequate ongoing treatment or end of life care discussion with Mrs Coates's family.
- At the time of Mrs Coates's admission, the UKCC guidance required nurses to carry out a comprehensive assessment of the patient's nursing requirements and devise, implement and keep under review a nursing care plan. The UKCC guidance also required nurses to create and maintain medical records in order to provide accurate, current, comprehensive and concise information concerning the condition and care of the patient. Such records would include details of observations, problems, evidence of care required, action taken, intervention by practitioners, patient responses, factors that appear to affect the patient, the chronology of events, and reasons for any decision. These records would provide a baseline against which improvement or deterioration could be judged. Among other elements of care, *"Through their role in drug administration nurses are in an ideal position to monitor the drugs progress, reporting responses and side effects".* In this regard, the Panel found a lack of information in Mrs Coates's daily nursing notes and care plan records. The nursing notes and care plans seen by the Panel were scanty, lacked biographical data, were not personalised to the patient's needs and contained missing entries for entire days. For example, the 'Assistance to Settle at Night' care plan lacked entries for 19 of the days that Mrs Coates was admitted. There was nothing in the care plans that took account of Mrs Coates's capabilities, likes, dislikes and preferences.
- The Panel found no pain charts or pain management plans in Mrs Coates's medical records. It is not clear to the Panel how Mrs Coates's pain and the effectiveness of any analgesia were adequately monitored.
- The Panel has not seen any nutrition or fluid charts among Mrs Coates's medical records. Fluid and nutritional intake is an important part of the clinical picture.
- The specific plan of care for Mrs Coates is difficult to ascertain. It seems to have been to stabilise her diabetes and pain control. However, no plan appears to have been identified for pain control and there is no mention of psychological support/bereavement care, although she had recently lost her husband and was depressed.
- Overall, the Panel found a lack of detail in Mrs Coates's clinical and nursing notes. The clinical notes contained entries on 13 days only and the nursing notes contained entries on 15 days only.

How patients were treated: the roles and responsibilities of the clinical assistant

3.35 Key to looking at what happened at the hospital is an understanding of the roles and responsibilities of Dr Barton as the clinical assistant and how she discharged them.

3 Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.

3.36 Dr Barton took up her post as clinical assistant in the hospital on 1 May 1988 and she remained in this role for 12 years until tendering her resignation in April 2000 (NHE000212, p1).

3.37 This was a new post of five sessions a week, worked flexibly to provide 24-hour medical cover. The job description makes it clear that the post-holder must visit the wards on a regular basis, be available on call as necessary and fulfil the following requirements:

> "• To be responsible for the day to day Medical Management of the patients
>
> • To prescribe, as required, drugs for the patients under the care of the Consultant Physicians in Geriatric Medicine
>
> • To be available when required to advise and counsel relatives
>
> • To be responsible for liaison with the General Practitioners with whom the patient is registered and with other clinicians and agencies as necessary." (GMC101022, pp18–19)

3.38 Dr Barton had previously worked as a GP in Dorset and from 1980 in Gosport. On her application for the post, she described herself as a *"minimum full timer"*, working 20 hours a week on practice commitments (GMC101022, pp22–3). Dr Barton's practice was local to the hospital and she had around 1,500 patients on her list (HCO110482, p1).

3.39 The documents seen by the Panel show that there were no other applicants for the post (GMC101022, p24).

3.40 In NHS practice, the title 'clinical assistant' refers to a doctor, usually a GP, who provides care at a level below that of consultant. Except in designated GP beds, a consultant retains overall responsibility for the patient's care, but delegates some elements of day-to-day care according to their assessment of the capability of the clinical assistant.

3.41 The documents reveal how Dr Barton conducted herself once appointed. The Panel has looked at what Dr Barton herself said, at what others said about her and at what the medical records show.

3.42 Chapter 6 describes how the General Medical Council (GMC) subsequently examined Dr Barton's conduct. In those proceedings, Dr Barton said in March 2002 that of her five sessions as a clinical assistant, one and a half were allocated to partners in her GP practice to cover the out-of-hours aspect of the job. This left her with three and a half clinical assistant sessions and 48 long-stay geriatric beds. Dr Barton would subsequently explain in her statement to Hampshire Constabulary that, for the period up to 1998, she was engaged for four sessions each week, one of which was allocated to her GP partners for out-of-hours cover. According to Dr Barton, this reflected a change in her working conditions (HCO110482, p1).

3.43 Dr Barton described how she would visit the two wards, Dryad and Daedalus, at 7.30am, before arriving at her surgery at 9.00am. Towards the end of her period as clinical assistant, she would return at lunchtime most days in order to admit patients or to write up charts or see relatives; and, she said, she would quite often return at around 7.00pm, particularly to see relatives who were visiting in the evening.

3.44 Outside these hours, Dr Barton said:

> "The nursing staff would therefore ring me either at home or at my GP surgery to discuss developments or problems with particular patients. In the event that medication was to be increased even within a range of medication already prescribed by me, it would be usual for nursing staff either to inform me of the fact that they considered it necessary to make such a change, or they would inform me shortly thereafter of the fact that the increase had been made." (HCO110482, p1)

3.45 Dr Barton's own statements confirm that, on a day-to-day basis, she was the sole doctor available for the patients: *"Mine was the medical input"* (GMC101057, p22). When asked about responsibility for prescribing and *"would it always be you?"*, Dr Barton's reply was, *"It was generally me"* (p24).

3.46 The role of the clinical assistant in practice is confirmed by the following descriptions provided by nurses at the hospital:

- Nurse Siobhan Collins: *"I cannot recall anyone making criticisms of her during my time at the Hospital. I found that I never had any problem getting hold of her when I called, and she was always quite happy to be contacted. Dr Barton seemed very conscientious. She was always very pleasant, and was respectful of the views of nurses."* (MDU100001, p6)
- Nurse Fiona Walker: *"I never had any difficulty about contacting her for advice concerning a patient if that was necessary."* (MDU000002, p3)
- Sister Gillian Hamblin: *"Quite simply, she had so much to do that it was not possible for her to attend to all of her clinical duties in seeing and assessing, and indeed caring for the patients, and then making comprehensive notes about her reviews. In my view, the quality of her care was not compromised or limited, but given the constraints on time, she had no alternative but to keep her notes more limited in order for her to cope."* (MDU000004, p7)

3.47 The medical records seen by the Panel confirm Dr Barton's role in determining how drugs were prescribed and administered over her 12-year period as clinical assistant. Dr Barton was central to:

- providing an initial assessment and diagnosis of the patient
- prescribing any medication required
- liaising with the nursing teams
- providing day-to-day medical management of the patients and assessing their progress
- the standard of documentation in the medical records at the time
- decisions about discharge.

3.48 Dr Barton's role is very evident from quotations from families and from a range of case studies, including Case Studies 3 and 4.

A son recollected his mother's experience:

> "In fact [the doctor] said to me 'You know your mother is very unwell and we would like your permission to administer the necessary drugs to assist her through at the end.' Naturally, I was very distressed by this, and tearful, and expressed my amazement that I was being asked to sanction what appeared to be euthanasia. When we left the meeting room, [the doctor] commented to the nursing staff 'we've got another weeper here'."

Case Study 4 – Gladys Richards summary

Patient story

In 1998, Gladys Richards was aged 91 and was resident in a nursing home. By February 1998, she had been diagnosed with severe dementia. In May, Mrs Richards was described as *"withdrawn and anxious at times"* but as being settled most of the time. Mrs Richards wore pads for incontinence, had hearing difficulties, required help with washing and dressing and needed encouragement and help to eat. She would usually sleep through the night but at times would get up and wander. Mrs Richards' daughters and granddaughter were heavily involved in her day-to-day care and visited her daily at the nursing home. By July, Mrs Richards had a six-month history of falls at the nursing home and her daughters were unhappy with the care she was receiving.

On 29 July, Mrs Richards fell and fractured her right neck of femur. She was admitted to the Royal Hospital Haslar ('Haslar Hospital'), where she underwent a partial hip replacement. On 11 August, Mrs Richards was admitted to Gosport War Memorial Hospital ('the hospital') for rehabilitation. On 13 August, Mrs Richards fell and dislocated her right hip. On 14 August, she was transferred to Haslar Hospital where the dislocation was treated. On 17 August, Mrs Richards returned to Gosport War Memorial Hospital where she remained until she died on 21 August.

Care received

Following surgery at Haslar Hospital, Mrs Richards was able to move her left leg quite freely, appeared to have a little discomfort on passive movement of the right hip, and had been sitting out in a chair. On 5 August 1998, Dr Richard Ian Reid concluded that *"despite her dementia she should be given the opportunity to try to re-mobilise"* and confirmed that he would arrange Mrs Richards' transfer to Gosport War Memorial Hospital.

Mrs Richards was transferred on 11 August. She was not fully weight bearing; however, she was walking with the aid of two nurses and a Zimmer frame. Mrs Richards needed total care with washing and dressing, eating and drinking. She had a soft diet and enjoyed a cup of tea. Mrs Richards was occasionally incontinent; if she was fidgety and agitated it meant she wanted the toilet. Her recommended drug treatment on transfer to the hospital was haloperidol suspension, lactulose and co-codamol.

Dr Jane Barton saw Mrs Richards on her admission to the hospital. She noted that Mrs Richards had been transferred for continuing care and was a frail, demented lady. Dr Barton wrote in the records: *"not obviously in pain please make comfortable … I am happy for nursing staff to confirm death."*

Dr Barton wrote a prescription for morphine oral solution 2.5–5 ml (5–10 mg morphine) every four hours as required, and diamorphine 20–200 mg, hyoscine 200–800 micrograms and midazolam 20–80 mg to be administered by subcutaneous infusion over 24 hours. On 12 August, Dr Barton wrote further prescriptions for morphine oral solution 2.5–5 ml (5–10 mg morphine) every four hours and 5 ml (10 mg morphine) in the evening as required. Three doses of morphine oral solution 10 mg were administered to Mrs Richards on 11 and 12 August. On the evening of 12 August, Mrs Richards was drowsy, had difficulty settling for the night and was agitated, shouting and crying but did not seem to be in pain.

In relation to the prescriptions, Dr Barton stated in an interview with Hampshire Constabulary in July 2000:

> "[Mrs Richards] was pleasant and co-operative on arrival and did not appear to be in pain. Later … [she] was screaming … In my opinion it was caused by pain … Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including oral morphine solution and diamorphine."

During the 2009 General Medical Council (GMC) Fitness to Practise (FtP) hearing, Dr Barton stated:

> "The snapshot view that I gained … was that she was not obviously in pain; but [given her recent surgery] I was minded to make available to the nurses a small dose of oral opiate in order to make her comfortable during that time … I felt [her] general outlook was poor. She was quite possibly going to need end of life care sooner rather than later."

In relation to the notes she made, Dr Barton also told the police:

> "[Mrs Richards] was probably near to death, in terms of weeks and months from her dementia before the hip fracture supervened. Given [her admission and surgery] I appreciated that there was a possibility that she might die sooner rather than later. This explains my reference at that time to the confirmation of death, if necessary by the nursing staff."

In 2009, Dr Barton told the FtP hearing:

> "That was a routine entry I made into the notes of patients who might at some time in the future die on the ward [so that] … nursing staff … did not have to bring in an out of hours duty doctor to confirm death … it did not signify at that time I felt that she was close to death; it was a fairly routine entry in the notes."

At 13:30 on 13 August, Mrs Richards was found on the floor. No injury was noted at the time. By 19:30 she had pain and morphine oral solution was later administered. No other action was taken in respect of Mrs Richards' condition that evening. The next day, Mrs Richards was still in pain. Morphine oral solution was administered to her and an X-ray revealed that her right hip was dislocated. Following discussion between Dr Barton and the clinician at Haslar Hospital, Mrs Richards was transferred back to Haslar Hospital where the dislocation was treated under sedation. The procedure was uneventful and Mrs Richards remained in Haslar Hospital for two days.

On 17 August, Mrs Richards was transferred back to Gosport War Memorial Hospital. She had been given a canvas knee-immobilising splint which was to stay in place for four weeks. Haslar Hospital advised that Mrs Richards could *"mobilise fully weight bearing"* and that, when she was in bed, it was advisable to encourage abduction by use of pillows or a wedge. Haslar Hospital made it clear that there would be *"no follow up unless complication".* Mrs Richards arrived at Gosport War Memorial Hospital in pain and distress. She had been transferred by the ambulance crew on a sheet rather than on canvas. Mrs Richards was given four doses of morphine oral solution between 13:00 and 20:30.

In the early hours of 18 August, Mrs Richards was still in pain and two further doses of morphine oral solution were administered to her. Dr Barton assessed Mrs Richards in the morning and noted, *"still in great pain, nursing a problem I suggest s.c. diamorphine / haloperidol / midazolam … please make comfortable".* She wrote another prescription for diamorphine 40–200 mg over 24 hours.

In July 2000, Dr Barton told the police that there was a lot of swelling and tenderness around the area of Mrs Richards' prosthesis, that in her assessment Mrs Richards had *"developed a haematoma or a large collection of bruising around the area where the dislocated prosthesis had been lying whilst dislocated",* and that this was in all probability the cause of Mrs Richards' pain. Dr Barton stated her view was that *"this complication would not have been amenable to any surgical intervention"* and that transfer to Haslar Hospital was not in Mrs Richards' best interests.

In 2009, Dr Barton told the FtP hearing:

> "I knew that nothing surgically could have been done for this condition and that it would just have to be allowed to heal in its own time, if her condition permitted and she remained well enough … I did not feel that a transfer back to an acute unit at that point was in [Mrs Richards'] interests. She probably would not have even survived the journey back, so we had to continue on our route of palliative care, becoming terminal care."

On 18 August, at 11:45, the administration of diamorphine 40 mg, haloperidol 5 mg and midazolam 20 mg was commenced by syringe driver. The daily administration of these drugs, plus hyoscine, by syringe driver continued until 21 August, when Mrs Richards died.

Panel comments

11 and 12 August 1998

- Morphine oral solution, and diamorphine, midazolam and hyoscine were prescribed in high and very wide dose ranges.
- The Panel has not found any document in the medical records to show that morphine oral solution, and diamorphine, midazolam and hyoscine were clinically indicated.
- The Panel has not found any document in the medical records to show Dr Barton's rationale for prescribing morphine oral solution, diamorphine, midazolam and hyoscine.
- Dr Barton did not record any of the explanations she gave to Hampshire Constabulary, or the GMC FtP hearing, in Mrs Richards' clinical notes at the time of her assessment.
- It is not clear from the medical records why Dr Barton requested that Mrs Richards be *"made comfortable"* (be treated palliatively) and noted that she was *"happy for nursing staff to confirm death"* in circumstances where Dr Reid had decided Mrs Richards should be given the opportunity to remobilise.
- The Panel has not found any document in the medical records to confirm that Mrs Richards was screaming as if in pain on 11 or 12 August.
- It is not clear to the Panel why Dr Barton did not discuss her differing views and prognosis with the consultants at Gosport War Memorial Hospital and Haslar Hospital, or with any members of Mrs Richards' family.
- The Panel has not seen any document in the medical records to confirm that nurses scrutinised, questioned, challenged or refused to administer the proactive and wide dose range prescriptions of morphine oral solution, diamorphine and midazolam.
- The Panel has not seen any document in the medical records to show the nurses' rationale for administering three doses of morphine oral solution and for choosing a 10 mg starting dose, which was the highest dose in the range prescribed by Dr Barton, on 11 and 12 August.
- The Panel has not seen any document in the medical records to show that nurses consulted the British National Formulary (BNF) guidance, the Wessex guidelines,[4] any doctor or the pharmacist when commencing the administration of morphine oral solution 10 mg.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of morphine oral solution or the choice of starting dose.

17 to 21 August 1998

- The Haslar Hospital transfer letter stated *"no follow up unless complication".* It is not clear to the Panel why Dr Barton did not consult with the clinicians at Haslar Hospital about Mrs Richards' haematoma, treatment and transfer in light of the apparent complication and having previously decided that consultation with Haslar Hospital was necessary.
- The Panel has seen no record in the clinical notes to suggest that Mrs Richards had a haematoma.
- It is not clear to the Panel why Dr Barton did not investigate the presence and the nature of any haematoma.
- It is not clear to the Panel on what basis Dr Barton determined that any haematoma was not amenable to surgical intervention or any other form of treatment.
- Dr Barton did not record any of the explanations she provided to the police or to the FtP hearing in Mrs Richards' clinical notes at the time of her assessment.
- The Panel has found no document in the medical records to confirm Dr Barton's rationale for increasing the dose range of diamorphine to 40–200 mg.

4 Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.

- The administration of diamorphine 40 mg over 24 hours by syringe driver in a patient who had received 45 mg of morphine oral solution in the previous 24 hours constitutes more than double the effective dose of morphine. The Panel can find no justification in the clinical records for this increase in dosage.
- The Panel has not seen any document in the medical records to confirm that nurses scrutinised, questioned, challenged or refused to administer the high and wide dose range prescription of diamorphine.
- The Panel has not seen any document in the medical records to show the nurses' rationale for administering diamorphine 40 mg and midazolam 20 mg.
- The Panel has not seen any document in the medical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of diamorphine, midazolam and hyoscine.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or the Trust on when to commence the administration of morphine oral solution or the choice of starting dose.

General comments

- The Panel found a lack of information in Mrs Richards' daily nursing notes. The care plans seen by the Panel were scanty, were not personalised to Mrs Richards' needs and contained missing entries for entire days.
- The Panel has not seen any document in the medical records to confirm that the nurses implemented any form of pain management plan. It is not clear on what basis Mrs Richards' response to analgesia was being assessed and determined.
- The Panel has found no document to confirm that any assessment of Mrs Richards' cognitive impairment was carried out, or that it was the subject of a care plan.
- The Panel has not seen any fluid charts among Mrs Richards' medical records and the nutrition plan was a proforma which contained scanty entries for 13, 14 and 21 August only.
- The Panel has not seen any document in the medical records to show that the nurses took into account the possible side effects of morphine when noting Mrs Richards' condition.

How patients were treated: the roles and responsibilities of the consultants

3.49 Each patient, unless in a GP bed, would have been under the care of a named, designated consultant; this is a requirement of NHS practice. The available records for 1988 refer to two consultants in post who were responsible for patients at the hospital: Dr John Grunstein, the consultant physician for elderly services, who received Dr Barton's application; and Dr PS Wilkins.

3.50 Dr David Jarrett was described as the Lead Consultant for Elderly Medicine in 1998 (HCO109815, p5).

3.51 Dr Bob Logan was a consultant geriatrician in the Portsmouth area, responsible for supervising the care of a wide range of elderly people. He subsequently described his responsibilities as including consultant cover for Redclyffe Annexe until 1992 or 1993, but not for other wards at the hospital. Dr Logan described visiting Redclyffe Annexe once every two weeks and being available for consultation between ward rounds. He was clear that the clinical assistant had day-to-day clinical responsibility for the medical care of the patients (HCO006896).

3.52 Dr Althea Lord worked as a consultant geriatrician for elderly medicine in Portsmouth from March 1992 until June 2004. This role extended to Gosport War Memorial Hospital (including

Daedalus and Dryad wards) as well as other hospitals in the area (MDU000001, pp2–3). When Dr Jane Tandy was on maternity leave in the period until February 1999, Dr Lord covered her duties on Dryad Ward (HCO110482). Dr Lord described her involvement in these terms:

> "… re-building took place at the hospital in about 1994 or so with the construction of new facilities including Daedalus and Dryad wards at the hospital. I then became the Consultant responsible for the patients on Daedalus and Dryad wards and would carry out a ward round on each ward every other week." (MDU000001, p2)

3.53 Dr Tandy worked as a consultant geriatrician from 1994, including overall medical responsibility for Dryad Ward until 1996. Dr Tandy confirmed that her responsibilities included a ward round on Dryad Ward once a fortnight. She would normally be accompanied by a senior member of the nursing staff as well as Dr Barton. Dr Tandy's usual routine, when conducting a ward round, would be to see all the patients. She described discussing the care of the patients with the ward team, talking to patients and examining them if appropriate (HCO110808, p2).

3.54 In her statement to Hampshire Constabulary in 2004, Dr Tandy said:

> "… one of my responsibilities was to review the prescription of drugs on Dryad ward at Gosport War Memorial Hospital. The majority of drugs can only be prescribed by a doctor. The day-to-day administration of drugs would be by qualified nursing staff … Drugs can only be prescribed by a doctor. Drugs could be modified, current drugs stopped or new drugs added depending on the patient's condition. The drug regime would be reviewed by the consultant on the ward round as appropriate during the week by the general practitioner (GP) where necessary. There was no requirement to notify me of every change to drugs prescribed to the patient by the GP during his or her ward round unless the GP sought my advice. From my experience it was very infrequent that the doctor would phone me for advice." (HCO110808, p2)

3.55 In referring to her respective responsibilities and those of the clinical assistant, Dr Tandy said: *"At this time in 1996 there was not a resident doctor for these patients on Dryad Ward. Day to day cover was provided by the local GP. In the case of Dryad Ward this was Dr BARTON and possibly others from her practice"* (HCO110808, p2).

3.56 Dr Richard Ian Reid was appointed in April 1998 to a role which combined working as a consultant in geriatric medicine with the post of Medical Director of Portsmouth HealthCare NHS Trust. In his statement to the police in 2006, Dr Reid said that while, in theory, the two parts of his role were evenly spread, in practice his work as medical director amounted to two-thirds of his time (HCO109815).

3.57 Dr Reid was concerned to clarify that his appointment as medical director related to the Trust and did not make him the medical director for Gosport War Memorial Hospital. At the hospital, Dr Reid was consultant for Dryad Ward, on his account for about a year from the spring of 1999. He said that he also provided cover for Dr Lord on Daedalus Ward but did not conduct her weekly ward rounds, instead operating on the basis of being available in an emergency (HCO109815).

3.58 Dr Reid indicated that he would spend around three hours in the afternoon on the ward round before seeing relatives and writing up notes (HCO109815).

3.59 When questioned by the police about his contact with Dr Barton, Dr Reid said that if she was on the ward round *"she would clearly ask me about problems"*. He added: *"I was always available in terms of certainly telephone contact if she wanted to discuss something"*

(HCO006981, p34). In her statement, Dr Barton described Dr Reid as *"nominally in charge of Dryad"* while emphasising his other commitments away from the hospital (HCO110482, p1). Dr Reid did not appear to appreciate the risks of the prescribing practice and overuse of diamorphine affecting his own patients. He was in an ideal position to investigate this further and would have had a major responsibility for clinical governance within the Trust.

3.60 The Panel has seen accounts explaining how the consultants worked in relation to the clinical assistant. Nurse Collins, for example, said:

> "I anticipate that the Consultants had 100% trust in Dr Barton and they did not feel the need to oversee a lot of her work. Their main input would be in the next step in the patient's care, in terms of deciding whether the patient should be transferred to a nursing home, or kept on the Ward, if the patient should go to rehabilitation or should go home for a period." (MDU100001, p3)

> "In my view, Dr Barton did not have sufficient consultant input, not in the sense that she did not know what to do, but simply in terms of demands on her time. These demands were very high … It seemed to me that no sooner had a consultant found their feet than they then moved on." (MDU100001, p5)

> "The Consultants responsible for Dryad Ward must have been aware of the practice of prescribing drugs in this [anticipatory] way. It was there for everyone to see on the medical records, which would be reviewed when the Consultants carried out their Ward Rounds each week. However, I never heard any expression of disquiet or concern from Consultants about the operation of this policy. I think the Consultants may also have operated this system of prescribing on occasion." (MDU100001, p8)

3.61 The descriptions of their responsibilities confirm the statutory position that the consultants, though not present and involved on a daily basis, retained responsibility for patients on the wards. The nature of their involvement in practice is revealed by the case studies examined by the Panel. These case studies include Case Study 5, which is published here in its summary form, with the fuller version at Appendix 2.

Case Study 5 – Elsie Devine summary

Patient story

- In 1999, Elsie Devine was aged 88 and lived with her daughter and her family. Mrs Devine had lost her husband 21 years earlier but had remained independent and self-caring, able to do her own cooking and cleaning. In January 1999, she started to experience some decline in her memory. Mrs Devine had a history of moderate chronic renal failure and in April the possibility of myeloma was considered. A skeletal survey was carried out. Myeloma was not diagnosed. By September, Mrs Devine's oedema had worsened and her kidney function had deteriorated.
- On 9 October, Mrs Devine was admitted to Queen Alexandra Hospital. In the days before admission she had become confused and aggressive and had been found wandering. On 21 October, Mrs Devine was admitted to Gosport War Memorial Hospital ('the hospital') for rehabilitation. On 21 November, Mrs Devine died.

Background, care and treatment

Mrs Devine was admitted to Queen Alexandra Hospital on 9 October 1999. In the days before admission she had become confused and aggressive and had been found wandering. She was treated with antibiotics for a urinary tract infection and was referred to the Mental Health Team.

Between 15 and 20 October, Dr Taylor, a clinical assistant in old age psychiatry, and Dr Jayawardena, a consultant geriatrician, assessed Mrs Devine at Queen Alexandra Hospital. They noted that her behaviour was settled and she was suitable for rehabilitation and transfer to Gosport War Memorial Hospital as a temporary placement until a permanent placement could be found. She was diagnosed with dementia. However, Mrs Devine's condition had improved, her behaviour was settled and she was ready for discharge.

On 21 October, Mrs Devine was transferred to Dryad Ward at the hospital under the care of Dr Richard Ian Reid, pending her return home or to an appropriate residential home. On admission to the hospital, Mrs Devine was assessed by Dr Jane Barton, who noted: *"… Plan: - get to know, assess rehab. potential, probably for rest home in due course."* Dr Barton prescribed morphine oral solution 2.5–5 ml (5–10 mg morphine) four hourly as required.

In relation to the morphine oral solution prescription, Dr Barton stated in an interview with Hampshire Constabulary in November 2004: *"I was concerned that a low dose of pain relieving medication should be available for [Mrs Devine] in case she experienced distress and discomfort and a Doctor was not available to write up a prescription for her."*

During the 2009 General Medical Council (GMC) Fitness to Practise (FtP) hearing, Dr Barton stated:

> "At some time in the future, during her admission I imagine that she might suffer from pain from her chronic renal problem or pain and distress at the end stages of her dementia, and I wanted to have it there on the drug chart should we need it in the future. I was not anticipating using the drug at that time."

The Panel has not seen any record of the administration of morphine oral solution.

Between 25 October and 1 November, Dr Reid assessed Mrs Devine and noted that she was *"Mobile unaided, washes with supervision, dresses self, continent, mildly confused"* and was *"physically independent but needs supervision with washing and dressing, help with bathing".*

On 10 November, Mrs Devine was noted to be confused and wandering. The following day Dr Barton prescribed temazepam, trimethroprim and thioridazine *"because [she] thought clinically [Mrs Devine] had a urinary tract infection … Thioridazine is a major tranquiliser … Not a chemical cosh in any way, but just to make her a bit less restless and agitated."*

By 11 November, the plan was to arrange for Mrs Devine to visit her home twice weekly to see her family and to assess if she would function better in her own home.

On 18 November, a locum staff psychiatrist from the Department of Elderly Mental Health assessed Mrs Devine and noted: *"This lady has deteriorated and has become much more restless and aggressive again. She's refusing medication and not eating well."* Her physical condition was noted to be stable and plans were made to transfer her to Mulberry Ward. Dr Barton prescribed a 25 microgram fentanyl patch every three days.

In relation to the fentanyl prescription, Dr Barton stated during a police interview in November 2004: *"This was in an attempt to calm her, to make her more comfortable, and to enable nursing care."*

During the 2009 FtP hearing, Dr Barton stated: *"In my mind at that point she was becoming end-stage dementia … and I thought that a transdermal patch at that point in time was a kinder way of controlling her symptoms … there were no physical signs of pain."*

On 19 November, Dr Barton assessed Mrs Devine and noted: *"marked deterioration … condition needs subcutaneous analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable; I'm happy for nursing staff to confirm death."* Dr Barton prescribed a subcutaneous infusion of diamorphine 40–80 mg and midazolam 20–80 mg over 24 hours. The nursing notes recorded: *"chlorpromazine 50mg given [intra muscularly] at 08.30. Taken two staff to special. Syringe driver commenced at 09.25 Diamorphine 40mg and Midazolam 40mg. Fentanyl Patch removed."*

In her police interview in November 2004, Dr Barton stated:

> "… on the morning of 19th November I found [Mrs Devine] in an extremely aggressive state, hanging onto the bars in the main corridor of the ward. She was clearly very agitated, anxious, and distressed. She would not allow anyone to approach her or administer any of her usual medication; In due course we were able to administer 50mg of Chlorpromazine … This took some time to be effective … This major tranquilliser had made her quite drowsy and we made the decision to discontinue the transdermal Fentanyl [and] Diamorphine [and] Midazolam … was prescribed …

> and was administered with the sole intention of relieving [Mrs Devine's] significant distress, anxiety and agitation, which were clearly very upsetting for her … she was now dying. The Fentanyl patch was removed a little later."

During the 2009 FtP hearing, Dr Barton stated:

> "… I suspected, her renal function had deteriorated quite quickly and quite markedly, and was probably contributing to the end stage dementia state that she was in. I did not think that it was related to the fentanyl. I thought that the fentanyl was not doing anything to make it better … [Although no active sign of pain] I wanted the midazolam. I needed the sedation and the anxiolytic properties of the midazolam in order to calm her down once the chlorpromazine wore off, and I was minded to continue an equivalent amount of diamorphine to replace the fentanyl dose that she had been having."

The 'Contact Records' found in the hospital records note: *"social services informed to close the case. Mulberry also informed."*

On 20 and 21 November, the syringe driver was recharged at 07:35 and 07:15 respectively. On 21 November, Mrs Devine died on Dryad Ward at 20:30.

Panel comments

21 October 1999

- The Panel has not seen any document to confirm that Mrs Devine went to Mulberry Ward before being transferred to Dryad Ward.
- There are no medical records to confirm on what basis Dr Barton prescribed morphine oral solution.
- The Panel has not seen any record to confirm that this drug was clinically indicated at any time.
- The Panel notes that Dr Barton did not record her rationale in the clinical notes at the time this decision was made.
- The Panel notes that Dr Barton did not prescribe simple analgesia.

18 November 1999

- The Panel has not seen any record to confirm that fentanyl was clinically indicated.
- The Panel has not seen any record of Mrs Devine experiencing pain.
- The Panel has not seen any fluid charts in the medical records. In the case of a patient with renal failure, fluid management is essential.
- The Panel has not seen any record to confirm that there were adequate attempts to rehydrate Mrs Devine.
- The Panel did not find any document in the medical records to confirm Dr Barton's rationale for prescribing fentanyl. It is clear from later records that the fentanyl patch was administered; however, this is not recorded on the drug chart. The Panel observes that the use of fentanyl might have compounded the deterioration in Mrs Devine's mental state.
- The Panel notes that Dr Barton did not record the rationale provided to the police and during the FtP hearing in the clinical notes at the time this decision was made.

19 November 1999

- The Panel has not seen any record to confirm that diamorphine and midazolam were clinically indicated at this time. In addition, the Panel has not seen any document in the medical records to confirm the rationale for the high starting doses.
- The Panel notes that Mrs Devine was an opioid-naïve patient with renal failure; however, she was commenced on a high dose of diamorphine.
- The Panel also notes that when diamorphine was administered, fentanyl would have been pharmacologically active in Mrs Devine's system despite the patch having been removed.
- There are no medical records to confirm on what basis Dr Barton prescribed diamorphine. There are no medical records to confirm the rationale for the dose of diamorphine. There are no medical records to confirm that diamorphine was clinically indicated. The Panel notes that Dr Barton did not record the rationale provided to the police and during the FtP hearing in the clinical notes at the time she made this decision.

General comments

- A number of clinicians variously and wrongly referred to myeloma as part of Mrs Devine's medical history.
- The acute confusion which led to Mrs Devine's admission and its subsequent improvement would be compatible with a diagnosis of delirium. The records indicate that Mrs Devine also had mild dementia.
- Mrs Devine was tested for a urinary tract infection and the result was reported as negative.
- There are no records to indicate that at any stage when prescribing or administering morphine oral solution, fentanyl or diamorphine, any account was taken of Mrs Devine's severe renal impairment.
- Mrs Devine's renal function had deteriorated but had not been managed. The records do not contain any recent fluid balance chart or any urine output records. The Panel has not seen any nutrition plan among Mrs Devine's hospital medical records. Fluid and nutritional intake is an important part of the clinical picture. Fentanyl, diamorphine and midazolam could impair Mrs Devine's ability to eat and drink.
- The Panel has not seen any document in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Mrs Devine's family.
- The Panel has not seen any record to confirm that nurses treating Mrs Devine challenged the proactive prescription of morphine oral solution, the prescription of fentanyl or the wide dose range in the prescription of diamorphine and midazolam. The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines;[5] nor did they question any of the consultants, doctors or the pharmacist at the hospital in respect of the prescriptions.
- The Panel has not seen any nursing document in the medical records to show the rationale for the decision to commence and continue the use of fentanyl, diamorphine and midazolam.
- The Panel has not seen any nursing document in the medical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of fentanyl, diamorphine and midazolam. The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on the administration of fentanyl, diamorphine and midazolam.
- The Panel found a lack of detail in Mrs Devine's daily nursing notes. The care plans seen by the Panel were scanty, were not personalised to the patient's needs and contained missing entries for entire days. There was nothing that took account of Mrs Devine's cognitive impairment, capabilities, likes, dislikes and preferences. The Panel found no pain charts or pain management plans in Mrs Devine's medical records. It is not clear to the Panel how Mrs Devine's anticipated pain and the effectiveness of any analgesia was to be adequately monitored.
- The Panel has not seen any document in the medical records to show that the nurses treating Mrs Devine understood or took into account the possible side effects of morphine when noting Mrs Devine's condition.

3.62 The consultants were responsible for the care given to their patients even when some elements of it were delegated to another doctor, in this case the clinical assistant. They were responsible for supervising her practice to the extent that they judged it necessary to ensure that care was being given safely and effectively. Either supervision was not carried out effectively or the consultants approved of the care given by the clinical assistant.

How patients were treated: the roles and responsibilities of the pharmacists

3.63 Pharmacy services to Gosport War Memorial Hospital were provided under a service-level agreement with Portsmouth and South East Hampshire Health Authority. This included the procurement and supply of medicines required, together with advice on their use, security and

5 Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.

custody. The contract was managed by the senior, chief pharmacist, and a second pharmacist provided the service. This arrangement appears broadly to have followed standard NHS pharmacy practices for remote non-acute hospitals at the time (DOH800198).

3.64 Portsmouth Hospitals NHS Trust and its chief pharmacist therefore had overall responsibility for pharmacy services at the hospital. The chief pharmacist was responsible for oversight of the procurement, control, storage and distribution of drugs for all Portsmouth hospitals, ensuring that there were procedures in place to maintain adequate and safe stocks in each ward area and that drugs were stored securely.

3.65 The chief pharmacist was also responsible for ensuring that advice and support were provided to ward staff; for training and development of the hospital's pharmacists; and, with the support of clinical staff and the Drugs and Therapeutics Committee, for ensuring that prescribing guidelines were adhered to and that the drug charts being used in the hospital were fit for purpose, safe and in line with national policy and guidance.

3.66 The chief pharmacist was a key member of the Trust's Drugs and Therapeutics Committee, which had broad oversight of prescribing policy and practice, including the appropriateness and affordability of new drugs introduced in the hospital.

3.67 At one stage the hospital had its own pharmacy department located within the outpatients department. It had been well established for many years and was staffed several days a week by a pharmacist from Portsmouth Hospitals NHS Trust, who made ward visits throughout Gosport War Memorial Hospital, including checks on controlled drugs. This facility was lost in the 1994–96 redevelopment and the on-site pharmacy was replaced by a remote service (RCN000037).

3.68 Subsequently, medicines were supplied to wards at the hospital in locked boxes directly from Portsmouth Hospitals NHS Trust pharmacy, against signed orders from a senior nurse on each ward. In line with universal good practice in the NHS, there was an additional system for signed orders, secure transit, and signed handover and receipt on the wards of controlled drugs. Pharmacist visits to the hospital continued twice a week and included checks on ward stocks and examination of patients' drug charts (HCO109728). The system was primarily aimed at maintaining adequate supplies, but there was also a mechanism for raising concerns. Jean Dalton, a community services pharmacist, said:

> "Daedalus ward would have been visited on a Thursday and that visit involves looking through the medical charts and checking for supplies and just generally checking whether things are appropriate … as I go through the charts I would also check for relevance of the medicines that are prescribed." (HCO109728, pp2–3)

3.69 The route for raising concerns was via the senior nurse to the clinical assistant or consultant. There was no systematic process for a review of prescribing. In the report of its investigation of Gosport War Memorial Hospital and Portsmouth Hospitals NHS Trust, the Commission for Health Improvement (CHI) described:

> "… a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital … 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 … it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned." (CQC100951, p33)

3.70 The CHI report, using the Trust's own medicines usage data, noted the excessive use of diamorphine and midazolam, which reached a peak in 1998/99. Over that period Dryad, Daedalus and Sultan wards used 1,617 doses of diamorphine and 1,650 doses of midazolam.

3.71 Among the documents reviewed by the Panel are references to the involvement of the pharmacist on the wards; for example, this statement from Sister Hamblin:

> "The Pharmacist for the Hospital, Jean Dalton, attended on the Ward each Monday, reviewing all the drug charts and the drug stock. She would give advice and guidance, but I do not believe she ever raised criticism, or that concern was ever expressed by her about the arrangements for prescribing in the way that we had adopted." (MDU000005, p2)

3.72 The documents record both the quantities of opioids used on the wards and the fact that the patients admitted were not in the main assessed as requiring palliative or end of life care. There is no evidence available to the Panel to suggest that either the pharmacists or Portsmouth HealthCare NHS Trust's Drugs and Therapeutics Committee challenged the practice of prescribing which would have been evident at the time.

Communication with families, including informal complaints

3.73 Communicating clinical decisions to both patients and families is a key aspect of care. The available documents do not provide a complete record of conversations involving patients, their families and the staff at the hospital. The Panel has compiled a number of case studies which include references illustrating the nature of the communication that took place. Case Study 6 is one such example.

Case Study 6 – Arthur Cunningham summary

Patient story

In 1998, Arthur Cunningham was aged 79. He was a widower. He was diagnosed with Parkinson's disease, dementia, reactive depression, diet controlled diabetes and myelodysplasia; he also had an old pelvic injury. Mr Cunningham was experiencing hallucinations and dystonic movements caused by his medication. His mobility was poor and although he could walk he also used a mobility scooter and wheelchair to aid mobilisation. Historically, Mr Cunningham had lived in supported accommodation but by June 1998 he was living in a nursing home and was a regular visitor to Dolphin Day Hospital, Gosport War Memorial Hospital, under the care of Dr Althea Lord.

On 21 July, Mr Cunningham was admitted to Mulberry Ward at Gosport War Memorial Hospital ('the hospital'). On 28 August, he was discharged to his nursing home. On 21 September, he was readmitted to the hospital for active treatment of a sacral sore. He was expected to return to his nursing home. On 26 September, Mr Cunningham died.

Background, care and treatment

On 21 July 1998, Mr Cunningham was admitted to Mulberry Ward at the hospital because renovations were taking place at his nursing home. On 27 August, Dr Lord reviewed Mr Cunningham and noted that he was fit for discharge the next day. On 28 August, Mr Cunningham was discharged to his nursing home. By 18 September, Mr Cunningham had *"settled well"* into the nursing home.

On 21 September, Mr Cunningham was reviewed by Dr Lord at Dolphin Day Hospital. She noted a *"large necrotic sacral ulcer which was extremely offensive".* Dr Lord admitted Mr Cunningham directly to Gosport War Memorial Hospital for active treatment of his sore. His nursing home was requested to keep his place open for a period of two to three weeks as he was expected to return there. Dr Lord noted *"prognosis*

poor". She prescribed morphine oral solution 2.5–10 mg, as required, four hourly, to be administered prior to dressing his sacral sore. Mr Cunningham was administered 5 mg of morphine oral solution at 14:50 and 10 mg at 20:15.

Dr Jane Barton, clinical assistant, also recorded in the clinical notes: *"Transfer to Dryad Ward. Make comfortable. Give adequate analgesia. I am happy for nursing staff to confirm death."* Dr Barton prescribed diamorphine 20–200 mg, midazolam 20–80 mg, hyoscine 200–800 micrograms, subcutaneously, as required, over 24 hours. At 23:10, 20 mg of diamorphine and 20 mg of midazolam were administered by continuous subcutaneous infusion.

Dr Barton recorded:

> "… syringe driver containing diamorphine, midazolam was commenced in the evening for pain relief and to allay his anxiety following an episode when [Mr Cunningham] tried to wipe sputum on a nurse saying he had HIV and was going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself."

In relation to the prescription for diamorphine and midazolam, Dr Barton stated in an interview with Hampshire Constabulary in April 2005:

> "I was concerned that … the [morphine oral solution] … might become inadequate … I decided to write up diamorphine on a proactive basis … These medications were prescribed by me purely with the aim of alleviating [Mr Cunningham's] significant pain, distress and agitation."

In 2009, Dr Barton told the General Medical Council (GMC) Fitness to Practise (FtP) hearing:

> "I was aware … that he would possibly very shortly be on an end-of-life pathway … I was also aware … that there had been problems with his tablets, difficulty swallowing them, and … we might well need to give this subcutaneously rather than as tablets or orally … I was minded to keep him comfortable, reduce any anxiety and distress he may have had. I was not considering him … as being terminal. I was, however … not very optimistic about his prognosis but I was not going to do anything to hasten his death or to his detriment … Both the diamorphine and the midazolam would have been ideal medication to control his discomfort, distress, anxiety overnight, as well as the pain he was receiving … So that was what the pro-active prescription was for."

On 22 September, at 20:20, 20 mg of diamorphine and 20 mg of midazolam were administered subcutaneously.

On 23 September, Mr Cunningham had *"become chesty overnight".* The syringe driver set up the evening before was paused and hyoscine added; there is no record on the drug chart that any remaining drug was discarded. At 09:25, the syringe driver was restarted with diamorphine 20 mg, midazolam 20 mg and hyoscine 400 micrograms to be administered over 24 hours. At 13:00, the clinical records note that Mr Cunningham's son was *"very angry that syringe driver has been commenced … now fully aware that [Mr Cunningham] is dying and needs to be made comfortable".* The drug chart further records *"discarded"* on the 09:25 diamorphine dose and, at 20:00, the administration of 20 mg of diamorphine, 60 mg of midazolam and 400 micrograms of hyoscine was commenced.

In her statement to the police, Dr Barton said: *"I anticipate that Mr CUNNINGHAM'S agitation might have been increasing, hence the increase in the level of Midazolam."*

During the FtP hearing, Dr Barton stated:

> "… he was becoming now terminally restless. This would have been in association with the bronchopneumonia he was now developing, hence the reason for administering the hyoscine and also increasing the midazolam … [this was] adequate sedation to make him comfortable during this terminal phase of his life."

The clinical notes record: *"Became a little agitated at 23:00hrs, syringe driver boosted with effect. Seems in some discomfort when moved, driver boosted prior to position change."* The notes further record that Mr Cunningham's catheter was draining but the urine was very concentrated.

On 24 September, Mr Cunningham was in pain when attended to and the diamorphine, midazolam and hyoscine were increased at 10:55. He was commenced on diamorphine 40 mg, midazolam 80 mg and hyoscine 800 micrograms by syringe driver over 24 hours. Dr Barton noted: *"Remains unwell. Son has visited again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death."*

In her statement to the police, Dr Barton said:

> "[The nurse] recorded a report from the night staff that Mr CUNNINGHAM was in pain when being attended to, and was also in pain with the day staff, though it was suggested that his was especially in his knees. In any event, the syringe driver was increased to 40 mgs of Diamorphine, and the Midazolam to 80 mgs [micrograms], together with 800 mcgs [micrograms] of Hyoscine."

During the FtP hearing, Dr Barton said that nurses had informed her that Mr Cunningham was becoming tolerant of the diamorphine and she needed *"to increase the dose a little bit to give him the same level of comfort".*

On 25 September, Dr Sarah Brook, a GP in Dr Barton's practice who assisted at the hospital, recorded in the clinical notes: *"remains very poorly on syringe driver, for TLC".* Dr Barton wrote another prescription increasing the ranges for diamorphine to 40–200 mg, midazolam 20–200 mg and hyoscine 800 micrograms–2 gm. The drug chart records that, at 10:15, diamorphine 60 mg, midazolam 80 mg and hyoscine 1,200 micrograms were administered by syringe driver over 24 hours.

In her statement to the police, Dr Barton said:

> "It appears then that the Diamorphine was increased to 60 mgs, with 90 mgs of Midazolam and 1200 mcgs of Hyoscine at 10.15 that morning. My expectation is that this increase was necessary to relieve … pain and distress. It is likely that by this time Mr CUNNINGHAM would have been becoming tolerant to opiates, and that might have added to the need to increase the doses of medication."

During the FtP hearing, Dr Barton stated that she did not see Mr Cunningham on this day.

On 26 September, the drug charts confirm that at 11:50 diamorphine 80 mg, midazolam 100 mg and hyoscine 1,200 micrograms were given by syringe driver over 24 hours. The clinical records note, on 26 September: *"[Mr Cunningham's] condition continued to deteriorate [and he] died 23:15."*

In her police interview, Dr Barton stated:

> "I anticipate that Mr CUNNINGHAM was experiencing further pain and distress, necessitating the increase, and that Dr BROOK would have agreed with it, though it is also possible that I might have been contacted prior to the increase by the nursing staff instead. In view of Mr CUNNINGHAM'S condition, with the significant pain from the large sacral sore, and the fact that he would have been becoming inured to the medication, that increase would have been necessary."

During the FtP hearing, Dr Barton confirmed that 26 September was a Saturday, that she did not see Mr Cunningham on this day and that she assumed he would have been seen by the duty doctor.

Panel comments

21 September 1998

- The Panel has not seen any document in the clinical records to confirm Dr Barton's rationale for prescribing diamorphine and midazolam at this stage.
- The Panel notes that Mr Cunningham was opioid naïve.
- The Panel notes the wide dose range of diamorphine which was prescribed in a patient who had renal impairment.
- Dr Barton did not record the explanations she provided to the police or to the FtP hearing in Mr Cunningham's clinical notes at the time of her assessment.

23 September 1998

- The Panel has not seen any document in the clinical records to confirm the rationale for the three-fold increase in the dose of midazolam commenced at 20:00 on 23 September.
- Dr Barton did not record the explanations she provided to the police or to the FtP hearing in Mr Cunningham's clinical notes at the time of her assessment.
- The Panel notes that the 23:00 boost was not recorded in the drug chart. The Panel has not seen any record to confirm the magnitude of the increase in dose.

24 September 1998

- The Panel has not seen any document in the clinical records to confirm the rationale for the two-fold increase in the dose of diamorphine and hyoscine and the one-third increase of midazolam.

- Dr Barton did not record the explanations she provided to the police or to the FtP hearing in Mr Cunningham's clinical notes at the time of her assessment.

25 September 1998

- The Panel notes that there was an error in the prescribed dose of hyoscine, which was written as mg rather than mcg (micrograms).
- The Panel has not seen any document in the clinical records to confirm the rationale for the increase in the prescribed dose range of diamorphine, hyoscine and midazolam.
- Dr Barton did not record the explanations she provided to the police in Mr Cunningham's clinical notes at the time of her assessment.

26 September 1998

- The Panel has not seen any document in the clinical records to confirm the rationale for the increase in diamorphine and midazolam.
- Dr Barton did not record the explanations she provided to the police in Mr Cunningham's clinical notes at the time of her assessment.

General comments

- The Panel has not seen any document in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Mr Cunningham's family.
- The Panel feels that in light of the reported anxiety of Mr Cunningham's son, an appointment with a consultant should have been made.
- The Panel has not seen any document to confirm that nurses treating Mr Cunningham challenged the proactive and repeated high and wide dose range prescription of diamorphine, midazolam and hyoscine.
- The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines[6] to scrutinise the doses; nor did they question any of the consultants, doctors or the pharmacist at the hospital in respect of the prescription and doses.
- The Panel has not seen any nursing document in the clinical records to show the reason or rationale for the decision to commence and continue the use of diamorphine and midazolam.
- The Panel has not seen any nursing document in the clinical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of diamorphine and midazolam.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of diamorphine and midazolam.
- The care plans seen by the Panel were limited in detail, were not personalised to the patient's needs and did not take account of Mr Cunningham's capabilities, likes, dislikes and preferences.
- The Panel found no pain charts or pain management plans in Mr Cunningham's clinical records. It is not clear to the Panel how Mr Cunningham's pain and the effectiveness of any analgesia were to be adequately monitored.
- The Panel has not seen any fluid charts or nutrition plan among Mr Cunningham's clinical records. Fluid and nutritional intake was an important part of the clinical picture. Diamorphine and midazolam could impair the ability to eat and drink.
- The Panel has not seen any document in the clinical records to show that the nurses treating Mr Cunningham understood or took into account these possible side effects of morphine when noting Mr Cunningham's condition.

3.74 From the case studies and its examination of a wide range of the clinical notes, the Panel has pieced together the following picture of communications.

6 Salisbury Palliative Care Services, 1995. *The Palliative Care Handbook: Guidelines on clinical management*, third edition.

3.75 Often at the same time as patients were admitted to the wards with a plan to return home with the support of the family following treatment, the clinical notes, as in a number of the cases, were stating, *"I am happy for my staff to confirm death"*. Meanwhile, the nursing notes for one patient recorded, *"slightly confused no hearing aid. Pt is compliant. Not in pain at the moment."*

3.76 This disparity between clinical expectations and those of the family reflects more than merely a communications issue. The records show that it translated into communications which were at best ambiguous as to whether the patient was going to live or die. For example, in one case where the family had agreed that their mother should be discharged to a nursing home after treatment, the son was told that *"she may need opiates to control her pain [and] he agrees to this"* (DOH700242, p7). It is clear from the son's subsequent reaction that the suggestion of agreement was based on a failure on the part of the clinical staff to communicate fully and honestly. In another case, the notes record, *"They are happy if we want to put up syringe driver"* (GMC100756, p86), and in a further case, *"she is aware he is dying and agrees to our plans to keep him comfortable"* (PLA000010, p14).

3.77 There is a pattern across the cases reviewed by the Panel. On admission or close to admission, there is an assumption, not shared with the family, that the patient is close to death regardless of the purpose of their admission or the clinical management plan in place. So when the clinical staff said to families that they were making their loved ones *"comfortable"*, that expression was a euphemism for embarking on the pattern of prescribing which would lead to death in almost every case.

3.78 The use of ambiguous or euphemistic terminology helps to explain how the records include accounts which, on the surface, seem to suggest that the clinicians were regularly communicating with families.

3.79 The records do not reveal whether the staff were using such ambiguous expressions with an intention to deliberately mislead. What the documents do show is that the pattern was frequent.

3.80 Reflecting the patronising attitude of the staff towards families, the records of conversations are often brief, cursory and dismissive, as these examples show:

> "Daughter seen, poor prognosis, stop feeding"
>
> "son aware patient dying"
>
> "she is aware he is dying and agrees to our plans to keep him comfortable" (PLA000010, p14)

3.81 The Panel notes that, in a few cases, there were well-recorded discussions of treatment plans for individuals. However, for the most part the records show snippets of brief exchanges characterised by ambiguous phrases reflecting the underlying attitude: the families were marginalised by the professional staff.

A daughter said of her father's treatment that she:

> "… had no idea at all why it [the syringe driver] was being used … we had never been consulted about this and were never made aware that my father was in so much pain that it necessitated its use. It just kept pumping."

3.82 The Panel has looked at whether the record of complaints from families, informal or formal, sheds light on their experience of how their loved ones were treated. Unfortunately, the weakness in record keeping means that there is little evidence now available. The Panel has seen evidence in a copy of a letter from the Assistant Business Manager to the personal assistant of the Chief Executive asking for the complaint files of a number of patients (DOH900615). Each name has an annotated reference code, suggesting a system for complaint management was in place. This is further supported by a request, on the same letter, for copies of any old complaints policies. None of these has been seen by the Panel.

3.83 The evidence which is available suggests that some families voiced concerns which included the drugs administered but their concerns went wider. The Panel has seen references to individual complaints, mainly informal, in one case dating from 1982 and in more cases from 1989. The lack of documentation in the intervening period prevents the Panel from describing the pattern of any complaints in that time or the response to those complaints.

3.84 From 1989 there is evidence of complaints which relate to four key areas of concern: hydration and nutrition; general nursing care; medical care; and use of opioid analgesia at a dose which made patients 'drowsy'. As Chapter 11 explains, the Panel established that a box of documents relating to complaints received by Portsmouth HealthCare NHS Trust was destroyed in 2013 ahead of its scheduled review date.

3.85 There is available documentation of one complaint that shows how when relatives complained about aspects of care, their complaints were poorly dealt with, and how warning signs of a serious problem with the prescription and administration of opioids and other medication were ignored. This was a complaint made about the care of Elsie Devine. Mrs Devine had previously been scheduled for discharge home, but shortly afterwards was given continuous subcutaneous diamorphine and midazolam because she had become confused and agitated; there was no apparent cause of pain and no recorded evidence that she was in pain (see Case Study 5). She died two days later. As local resolution did not resolve her daughter Ann Reeves' complaint, an Independent Review Panel (IRP)[7] was convened to consider it.

3.86 Although no guidance at the time or subsequently would support the use of opioids for confusion without pain, the IRP took a different view, and concluded that the clinical response was appropriate (CPS100289). The documents show no basis for the IRP's different view. When the complainant remained dissatisfied with the IRP report, a member of the IRP produced a further report:

> "[She] was wandering, agitated, acutely confused, disorientated and frightened. In a frail elderly person this is a very serious medical condition and may be as dangerous as a heart attack but it does not form part of the public perception of a serious or life threatening illness. For this reason she clearly required a large dose of strong

7 An Independent Review Panel is a part of the NHS complaints process: when local resolution is insufficient to satisfy the complainant, a convener establishes a panel drawn from outside the relevant Trust to report on the complaint.

> medication, as she was a danger to both herself and people around her. The fact that she was still responding to her daughter … (by squeezing her hand at the sound of her voice) that day and the next day suggested that the medications she was given was reasonable and was in the best interest of the patient to keep her comfortable. In conclusion, the [Independent Review] Panel found that the drugs, doses and devices used to make [the patient] comfortable on 19th November were an appropriate and necessary response to an urgent medical situation." (HCO003981, p8)

3.87 The Panel can find no basis in the documents or from its wider experience to justify this conclusion, which explicitly condones the use of large doses of diamorphine simply to control symptoms of confusion and agitation. The Panel notes that this conclusion was contrary to all relevant guidance.

Conclusion: what is added to public understanding

- **The Panel has found nothing in the medical or other records it has examined which undermines the startling account of Pauline Spilka. It is an account which is confirmed through a range of case studies the Panel has prepared in order to convey the experience of patients as recorded in their medical records while properly not publishing these records.**
- **The Panel has described an overall picture of nursing care which is disquieting when assessed against the standards prevailing at the time.**
- **The Panel has not applied a standard of perfection when comparing what the records show happened at the hospital with the formal standards and expectations. The Panel acknowledges the bravery shown by the nurses when they challenged the prescribing practice in 1991.**
- **The Panel also found a very poor standard of record keeping, including poor recording of the clinical justification for the commencement of drugs in relation to the patients' presenting condition.**
- **The medical records seen by the Panel confirm Dr Jane Barton's role in determining how the drugs were prescribed and administered over her 12-year period as clinical assistant. Dr Barton was central to:**
  - **providing an initial assessment and diagnosis of the patient**
  - **prescribing any medication required**
  - **liaising with the nursing teams**
  - **providing day-to-day medical management of the patients and assessing their progress**
  - **the standard of documentation in the medical records at the time**
  - **decisions about discharge.**

- **The Panel has found that, often at the same time as patients were admitted to the wards with a plan to return home with the support of the family following treatment, the clinical notes were stating, *"I am happy for my staff to confirm death"*.**

- **This chapter and its case studies have highlighted the shortcomings in the nursing care provided at the hospital as well as the excesses in the administering of drugs. The circumstances in which this happened can only be explained by looking at what the documents have revealed about the respective roles of the consultants and the clinical assistant, in conjunction with the nurses and the pharmacist. These are summarised in the following findings. By 'findings' the Panel reveals that which is found in the documents provided.**

Finding One: Responsibility of nurses to their patients

The nurses on the wards were not responsible for the practice of prescribing. They were responsible for administering the drugs, including via syringe drivers. The pattern of deaths as evidenced in Chapter 2, and the experience of patients as shown by the medical records highlighted in this chapter, show that the nurses should have seen the link between their administration of the drugs and the shortening of life which followed. Nurses had a responsibility to challenge prescribing where it was not in the interests of the patient; the records show that the nurses did not discharge that responsibility and continued to administer the drugs prescribed.

Finding Two: Responsibility of Dr Barton as clinical assistant

Over a 12-year period as clinical assistant, Dr Barton was responsible for the practice of prescribing which prevailed on the wards.

Finding Three: Responsibility of the consultants

Although the consultants were not involved directly in treating patients on the wards, the medical records highlighted in this chapter show that they were aware of how drugs were prescribed and administered but did not intervene to stop the practice.

Finding Four: Responsibility of the pharmacist

The documents record both the quantities of opioids used on the wards and the fact that the patients admitted were not assessed as requiring palliative or end of life care. There is no evidence available to the Panel to suggest that either the pharmacists or Portsmouth HealthCare NHS Trust's Drugs and Therapeutics Committee challenged the practice of prescribing which should have been evident at the time.

Finding Five: Nature of communication with families, including complaints

The Panel notes that in a few cases there were well-recorded discussions of treatment plans for individuals. However, for the most part, the records show snippets of brief exchanges characterised by ambiguous phrases reflecting the underlying attitude: the families were marginalised by the professional staff.

Part II

The concerns voiced by families and how they were heard

Chapter 4: Healthcare organisations and individuals

Introduction

4.1 Part I has described the practice of prescribing and administering drugs that were not clinically indicated and the resulting deaths. The purpose of this chapter is to examine how this pattern of practice could have remained in place undetected by others at Gosport War Memorial Hospital ('the hospital') for so long and the response to the concerns which did arise.

4.2 The scope of this chapter is the relevant systems and personnel in the hospital and in those NHS organisations responsible for its oversight. These included Health Authorities, NHS Trusts and NHS Commissioners, together with external health bodies such as the Commission for Health Improvement (CHI) and the Department of Health (DH). It does not cover professional regulatory bodies such as the General Medical Council (GMC) or the Nursing and Midwifery Council or its predecessor. These are covered in Chapters 6 and 7.

4.3 Systems to assure clinical quality have evolved significantly over the period covered by the Panel's work. The term 'clinical governance' was not introduced until 1997, but it is used in this Report to apply to all of the systems used to assure quality, and in particular the safety of patient care.

NHS quality assurance in the period

4.4 At the start of the Panel's timeframe, there were no formal systems to assure safety, and monitoring of patient care was rudimentary. The approach was entirely based on professional autonomy and self-regulation. Some clinicians undertook audits of their practice, but this was not mandatory and clinicians who did so were uncommon. Hospital administrators were there to facilitate the work of clinicians, and were not expected to challenge clinicians on either practice or behaviour.

4.5 In the 1980s, there were only two sources of information that might prompt concern in specific circumstances: complaints from patients and relatives, and clinical colleagues raising concerns about practice (later called whistle-blowing). Patient complaints most often prompted a defensive organisational response, with administrators preparing responses that were often less than open and transparent. On rare occasions the issues raised by complaints might have prompted referral to the GMC. More commonly, dissatisfied patients themselves took this step.

4.6 Raising concerns about clinical colleagues was fraught with peril for the whistle-blower, who was often confronted angrily by the clinician concerned, shunned by colleagues and, in some cases, obliged to emigrate to pursue their career.

4.7 The first change to this picture of complete professional autonomy began with the introduction of general management following the Griffiths Report on the NHS,[1] published in October 1983. Sir Roy Griffiths had said: *"If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge."* General management placed a manager in charge, but this was resisted strenuously by clinical professional bodies, and the view that clinicians were accountable only through professional self-regulation persisted for years in many places.[2]

4.8 The Health Authorities responsible for running services gradually adopted the view that clinical quality was a legitimate area of concern. There were still no formal systems to assure quality. The 1989 White Paper *Working for Patients*[3] introduced far-reaching changes to the NHS by separating the provision of health services from their commissioning. It remained silent on quality apart from a requirement for clinical audit. Monitoring clinical quality still depended on patient complaints and occasionally on whistle-blowing.

4.9 Further change did not come until 1997 when the White Paper *The New NHS: Modern, Dependable*[4] used a new term. It said that the Government *"will introduce a system of 'clinical governance' in NHS Trusts to guarantee quality"*. NHS Trust Boards became formally accountable for clinical quality and were required to set up monitoring systems, including those assuring patient safety. This White Paper also led to the establishment of CHI, charged with assessing clinical quality in NHS organisations and carrying out investigations into serious failures.

4.10 NHS Trusts varied markedly in their readiness to adopt these arrangements. Some were still struggling to implement effective clinical governance over a decade later, as shown by inspections carried out across the country by CHI and its successors the Healthcare Commission and the Care Quality Commission (CQC). The requirement was clear: NHS Trusts should have had effective clinical governance, including monitoring patient safety, from around 2000 at the latest, and should from then have been well equipped to respond to any concerns that arose about the quality of clinical services.

4.11 It is important to place the documents relating to clinical governance at the hospital within this context and to take account of how it developed nationally over the time period covered by the Panel's work.

Concerns about patient safety at the hospital

4.12 At the time that the first recorded concern arose about clinical practice at the hospital in 1991, it was managed by Portsmouth and South East Hampshire Health Authority, as a directly managed unit. Chapter 1 of this Report explains how the nurses raised concerns about the drugs prescribed and used in Redclyffe Annexe. It notes that the meeting on 17 December 1991 appeared to have the effect of closing down the nurses' concerns. The documents provided to the Panel do not include any further notes or correspondence from this time. The evidence therefore suggests that there was no further action taken in the hospital to follow up the concerns.

1 Griffiths R, 1983. *NHS Management Inquiry*. Department of Health and Social Security.
2 Davies P, 2009. The Griffiths Report: 25 years on. *HSJ*, 5 June.
3 Department of Health and Social Security, 1989. *Working for Patients*. The Stationery Office.
4 Department of Health, 1997. *The New NHS: Modern, Dependable*. The Stationery Office.

4.13 As is made clear in an unpublished subsequent external report, in February 2003, *"the failure to follow-up the expression of concerns made by nursing staff about prescribing practice in Redclyffe Annexe from 1988 was a negligent act by the Unit Management Team … Managers seem to have placed too much reliance on the unwillingness of junior nurses to speak out in front of GPs at a meeting held on 17 December 1991"* (DOH702113, p4).

4.14 Between 1992 and the receipt of a complaint following the death of Mrs Gladys Richards in 1998, the only documented activity of even marginal relevance relates to audits of the prescribing of benzodiazepines and night sedation in 1995/96 and 1997, drug cards on Mulberry Ward in 1997, and medical record keeping in 1997 (DOH604186, DOH604182, DOH604184, MRE000139). Although these identified various shortcomings in record keeping and review, there is no discernible link with the previous concerns and none of the audits picked up any other prescribing matters.

Subsequent patient safety concerns

4.15 In 1994, hospital and community services in Portsmouth, including Gosport War Memorial Hospital, became part of Portsmouth HealthCare NHS Trust. Although this meant a change of management arrangements and of some managers, there was as elsewhere little change in the approach to assuring patient safety. There is a gap in the documents provided to the Panel relating to Portsmouth HealthCare NHS Trust. From the documents which have been made available, it seems clear that the rise in the inappropriate use of opioids and other drugs over the course of 1994–1998 documented previously in this Report went undetected by the new Trust.

4.16 Then, in 1998, a complaint was made about the treatment of Mrs Richards, who died on 21 August 1998. Documents seen by the Panel disclose that the complaint was made verbally to Lesley Humphrey, Director of Quality, Portsmouth HealthCare NHS Trust, and that Sue Hutchings, Investigating Officer, started an internal investigation on 24 August 1998. The investigation report shows that William (Bill) Hooper, the General Manager for the hospital at the time, commissioned the investigation.

4.17 The documents further show that the investigation report included reference to medication administered via a syringe driver:

> "Sadly, Mrs. Richards's death was not as [the complainant] had hoped it would be. She felt the use of the syringe driver made her mother become unconscious and she did not say her 'goodbye', although both she and her sister were with their mother almost continuously day and night during Mrs. Richards last few days." (DOH604052, p6)

4.18 Although this section of the report makes it clear that the syringe driver was one of the elements of Mrs Richards' care that the complainant was unhappy about, it was not identified as one of the questions raised by the complaint, and the report did not identify the contents of the syringe driver (diamorphine, midazolam, hyoscine and haloperidol). It is notable that Mr Hooper, who commissioned and presumably received the report, was one of the managers involved in the response to the nurses' concerns over opioid use seven years previously, yet there is no evidence that any link was made.

4.19 In August 1998, Mrs Richards' daughter reported her mother's death to Hampshire Constabulary, and a police investigation commenced that is assessed in Chapter 5. We could

find no documentary evidence that this prompted concern by clinicians or managers over the safety of the Trust's services.

4.20 Although she did not see Mrs Richards during her final admission, Dr Althea Lord was the consultant with responsibility for Mrs Richards' care. Dr Lord provided a written account for Lesley Humphrey dated 22 December 1998 to pass to the police (DOH604059). The first of Dr Lord's itemised comments in this account refers to the use of diamorphine via a syringe driver, indicating that this was now a key element of the investigation. Again, however, we could find no evidence that this prompted concern from the Trust, nor that it was linked with the nurses' concerns in 1991.

4.21 Following the completion of the initial police investigation, with no charges being brought, both Hampshire Constabulary and the Trust received further complaints about other patients during 1999. In addition, Hampshire Constabulary informed Max Millett, by now the Trust's Chief Executive, that the investigation into Mrs Richards' death was being reopened (DOH604060).

4.22 One complaint in 1999 prompted the Trust to seek external advice from Dr Gill Turner, Clinical Services Director of an elderly care unit in Southampton. Although her advice was that *"the use of Morphine was entirely appropriate and … the amounts administered could not be considered excessive"* (DOH600573, p3), Dr Turner wrote separately to Mr Millett to express concerns about the inadequacy of the consultant cover on Dryad and Daedalus wards and, significantly, about the opioid prescribing regime:

> "Whilst recognising that in some of the peripheral units the medical staff providing daily cover are often from outside the hospital, I feel that writing Morphine up for a subcutaneous pump with doses ranging from between 20 and 200 mgs a day is poor practice and could indeed lead to a serious problem. As it happens the nurses stuck to using 20 mgs a day of Morphine in the subcutaneous pump and then increased it up to 40mg but they could of course have increased it up to 200 mgs given the way the chart is written. I think it unlikely that the jump from 20 to 40 mgs made any real contribution to [the patient's] management, but I think it is still a large jump and steps need to be taken to consider limiting the flexibility of dosage regime." (DOH600527, p2)

4.23 The external advice is clear that the practice of prescribing opioids up to a large dose could lead to a serious problem, but the response initially was that this was an agreed protocol, without which *"the patient may have to wait in pain while a doctor is called out who may not know the patient"* (DOH600522, p1). Lesley Humphrey wrote to the Medical Director of the Trust, Dr Richard Ian Reid, on 29 October 1999 to report a conversation with Dr Jane Barton, the clinical assistant, whose view was that *"the system of medical cover makes it difficult to prescribe otherwise"*. The email also refers to *"our concerns about the harassment clinicians seem to be facing from some complainants"*, but notes that *"this is our first opportunity to link a complaint into clinical governance – for positive action!"* (DOH600523, p1).

4.24 In response, Dr Reid produced a draft protocol for prescribing an opioid by syringe driver on 15 December 1999 (DOH600164). The documents do not show when it was implemented. Another pain management protocol was circulated later, in May 2001 (DOH901340). The Panel could find no reference to any audit of prescribing practice or case note review in response to the clear concerns raised by the complaints, the police investigation and Dr Turner's external advice. Even given that this was the Trust's *"first opportunity to link a complaint into clinical governance"*, this would have been an obvious response. The peak use of opioids apparent in 1998 could hardly have failed to reveal the nature of the problems.

4.25 Instead, when a workshop was held on 27 February 2001 to review the common themes emerging from five complaints about the hospital between 1998 and 2000, the three themes identified were communication with relatives, the attitudes of staff, and eating and drinking. The notes from the workshop make no mention of opioids or prescribing (DOH600915). Dr Barton had resigned her post as clinical assistant on 28 April 2000, citing concerns over *"staffing levels that do not provide safe and adequate medical cover or appropriate nursing expertise"* (NHE000212, p1).

Widening patient safety concerns

4.26 Although the Trust had failed to look for evidence of systemic problems with opioid prescribing, Hampshire Constabulary was by 2001 investigating five deaths at the hospital, and contacted CHI with its concerns (CQC100980, p7). Dr Barton had been referred to the GMC (DOH000434, p2). From this point, however, there is a lack of reference in any documentation from the Trust to suggest that it saw any clinical governance implications for itself. The deaths had become a matter for the police and for the GMC (DOH000435).

4.27 In contrast, there was an upsurge in references to the hospital and opioid prescribing there in documents from the South East Regional Office (SERO) and DH. SERO was one of eight regional offices established in 1996 as part of the NHS Management Executive, an arm's-length body responsible for NHS performance. The initial references to the hospital were prompted by the need to brief Ministers on the adverse publicity concerning the service (DOH000453).

4.28 An internal briefing was produced within DH on 5 April 2001, following local press coverage (DOH000452). The briefing covered the complaint about Mrs Richards' care, along with a note that the police investigation papers were with the Crown Prosecution Service; a second complaint that was not upheld by the Health Ombudsman; and a third where a complaint was not made to the Trust but reported in the local press. The briefing identifies factors common to all three, including the responsible consultant and the clinical assistant, but does not mention opioids. It concludes: *"Although there are factors common to the three cases mentioned, there is not sufficient evidence, at this time, to suggest that these deaths are linked or are the result of foulplay"* (DOH000453, p4).

4.29 Despite the reassuring tone of this briefing, by June 2001 DH officials had learned that the police had been in touch with both the GMC and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Allegations had been made of a *"culture of euthenasia at the hospital over long period; claims that 'troublesome' patients were given overdoses of diamorphine"*, but *"police are concerned that the regulatory bodies do nothing which could impede or imperil the investigation"* (DOH000451, p2).

4.30 On 20 June, the Chief Medical Officer, Professor Liam Donaldson, wrote to Ministers and senior officials in DH. He was *"concerned that action to protect patients should be well co-ordinated at local level"* as *"everything has been left with the GMC to consider whether to suspend … Are we confident that all appropriate action has been taken? Past experience has taught that a great deal of pressure has to be exerted centrally before these issues are gripped."* He asked that progress be reviewed *"as a matter of urgency"* (DOH000436, p1).

4.31 Kathy Doran, a DH official, replied to Professor Donaldson on 26 June to say that she had met with colleagues from SERO and that *"the local investigation has rested almost exclusively with the police"* (DOH000435, p1). She copied her note to the Chief Nursing Officer, Sarah Mullally, but the Panel has seen no response from Sarah Mullally in the documents provided.

4.32 At Kathy Doran's suggestion, Dr Peter Old, who had been appointed Director of Public Health for Portsmouth and South East Hampshire Health Authority in April 2001, had become involved and was instigating the Poorly Performing Doctors procedure for Dr Barton. It is notable that this was a procedure applicable to general practice, when the relevant events had occurred in hospital where Dr Barton had been a clinical assistant working to a consultant who retained overall responsibility for patients.

4.33 The procedure *"found no evidence of possible poor professional performance"* in general practice (DOH000409, p3). Despite this conclusion, Dr Old asked Dr Barton to stand down as Chair of Gosport Primary Care Group, which had been formed in April 2001 (DOH000429).

Commission for Health Improvement investigation

4.34 On 3 July 2001, the Chief Executive of Portsmouth and South East Hampshire Health Authority, Penny Humphris, wrote to Peter Homa, Chief Executive of the newly established CHI, asking if CHI could *"assist us locally with an inquiry"* as she was *"anxious to re-establish public confidence … The review, however, should not, concern itself with the specific circumstances of the complaints, as these are being investigated through other channels"* (DOH603461, p1). There is no documentary evidence that either the Health Authority or the Trust, or their successor organisations, conducted any systematic investigation of these events. In fact, the reference to *"other channels"* appears to be a reference to Hampshire Constabulary.

4.35 The response from Mr Homa was that he had already been asked to look at the hospital by these other channels (DOH603436). It appears from subsequent CHI briefing that this is also a reference to the police. Records show that, in addition, CHI was notified separately of concerns in July 2001 by Professor Gary Ford, who had provided an expert report at the request of Hampshire Constabulary (CQC100980, p7). CHI decided in September 2001 to carry out an investigation on the basis of the potential wider learning for the NHS (CQC100870). The CHI briefing for its Investigations and Fast Track Programme Board on 18 September 2001 notes that *"Detective Superintendent James [Hampshire Constabulary] thinks [the police investigation] is unlikely to lead to prosecution"* (CQC100870, p4).

4.36 On 15 August 2001, Mr Millett wrote to Margaret Tozer, Investigations Manager at CHI, enclosing previous papers on the complaint about Mrs Richards' care in 1998. His covering letter emphasised that the complainant's *"concerns and questions, as brought to our attention at the time, related to the events surrounding Mrs Richards unwitnessed fall"* and that the *"issue of palliative care, rather than active treatment and the use of syringe driver analgesia was not part of the original complaint raised with the Trust"* (NHE000767, p2).

4.37 Mrs Hutchings' internal report for the Trust included the observation that *"Sadly, Mrs. Richards's death was not as [the complainant] had hoped it would be. She felt the use of the syringe driver made her mother become unconscious and she did not say her 'goodbye'"* (RCN000013, p6). In the version of this report included with Mr Millett's letter to CHI, however, the reference to the syringe driver causing unconsciousness is missing and this alternative section of the report is quoted: *"Sadly, Mrs. Richards last few days and her death were not how her daughters had hoped her end would be, i.e. she did not regain consciousness and they felt they could not say 'goodbye'"* (NHE000767, p24).

4.38 The CHI investigation commenced in September 2001 and was due for completion the following year. Fareham and Gosport Primary Care Trust (PCT) inherited community services, including the hospital, from Portsmouth HealthCare NHS Trust in April 2002 (CQC100980, p2).

In view of the timescale, Professor Donaldson is reported as asking *"for reassurance that in the context of an allegation of a 'culture of euthanasia' apparently made in relation to care delivered at GWMH , and since the CHI investigation will not be complete until next year, the hospital is providing safe care"* (DOH000409, p2).

4.39 In his response, Dr Mike Gill, Regional Director of Public Health at SERO, concluded that whatever had happened in the past, the hospital was, by 5 October 2001, providing safe care:

> "There clearly was a period when prescribing policy was lax. On whether this in fact led to abuse there is conflicting evidence. Without wishing to prejudge the outcome of the CHI investigation, I and the DPH [Dr Peter Old] are satisfied that the care being provided is now safe, and that there are governance systems in place to ensure that. My sense is that a significant trigger to relatives going to the Police has been the brusque know-it all- style of the GP. Having had to review and overturn their own initial response to first complaint, the Police may feel under unusual pressure to leave no stone unturned." (DOH000409, p4)

4.40 CHI interviewed Mr Millett as part of its investigation on 7 January 2002 (CQC100495). The content of the interview notes confirmed that the major focus of the interview was on the functioning of Portsmouth HealthCare NHS Trust and its clinical governance. Mr Millett's responses were generally reassuring: he *"has made major changes in last couple of years"* and there is a *"whole new QMS [Quality Management System] with responsibility shared by senior management".* The interview notes record that the Nurse Director *"has 'uncovered some very uncomfortable things'".* Remarkably, there is nothing recorded to suggest that the interviewers asked what these were or what had been done about them (CQC100495, p1).

4.41 On 7 February, the Executive Team of Portsmouth HealthCare NHS Trust met to discuss a letter from Hampshire Constabulary. The letter enclosed three medical reports commissioned by the police that the Trust had not seen previously (DOH702173). The content prompted the Executive Team to withdraw the admission rights of Dr Barton to Sultan Ward, the GP-run ward at the hospital. Three nurses named in the medical reports were not considered to need suspension or investigation. Nor was Dr Lord, the responsible consultant, as *"the criticism in the reports is to do with her supervision of the clinical assistant, not her own clinical practice"* (DOH702173, p2).

4.42 Although most of this was ratified by the Trust's Clinical Governance Panel on 21 February, a question was raised during the meeting concerning the reliance on an unknown decision by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting in relation to the three named nurses. The Trust asked if *"Dr Reid would pursue the criticism in the reports about the supervision of junior staff and take whatever action was appropriate"* (DOH800093, p3). The notes of this meeting, and of the following meeting of the Clinical Governance Panel on 21 March, confirmed that the Trust was taking significant steps to assure itself of the safety of contemporary patient services (DOH800091). At the same time, it is notable that there is no suggestion in any of the records of identifying how widespread the prescribing practices had been in the 1990s, nor their impact on patients.

4.43 In April, responsibility for managing the hospital passed from Portsmouth HealthCare NHS Trust to Fareham and Gosport PCT, and responsibility for oversight passed to Hampshire and Isle of Wight SHA, one of 28 SHAs in England. The establishment of PCTs and SHAs had

been mandated nationally through *Shifting the Balance of Power Within the NHS*,[5] published in July 2001.

4.44 On 24 May, the newly appointed Director of Public Health for Hampshire and Isle of Wight SHA, Dr Simon Tanner, wrote to the Chief Executive Officer (CEO) of Fareham and Gosport PCT, Ian Piper, following a meeting to consider the impending publication of the CHI report on the hospital. Dr Tanner's concerns are instructive:

> "For the record, my own observations were these:
>
> - Following the original complaint (regarding a transfer) in 1998, why was there no formal consideration of disciplinary action against nursing or ambulance staff?
> - What was the view of the Director of Nursing Services and the Medical Director about standards of nursing and medical care in 1998?
> - Once the Chief Executive became aware of police involvement, why was the Trust Board not notified?
> - Why did the allegation of 'unlawful killing' not prompt action by the Trust, e.g. suspension of staff whilst an investigation was undertaken?
> - Why was no formal internal management review (other than the limited complaint investigation) commenced at any time between 1998 and now?
> - What action was taken by the Medical and Nursing Directors to investigate professional standards, in the light of the allegation?
> - Once the issue of unusual prescribing was raised, was there any immediate internal review of prescribing records to determine irregularities or trends?
> - Why did it take until mid-2001 before a formal audit of prescribing took place?
> - As an employee of the Trust, was the GP clinical assistant subject to any management review or action?
> - What action was taking place through 1999, 2000 and 2001? Was there an agreed action plan developed and monitored to reassure the Board that changes were being made to practice?
> - Are the passage of time, the existence of changed policies and the current records of individuals sufficient reasons for deciding not to pursue disciplinary action, in the face of serious concerns about past conduct, backed up by objective evidence?
> - What information would have triggered a referral by the Trust, of professionals to their regulatory bodies?" (DOH601158, pp1–2)

4.45 This list of 12 pertinent questions is important, and quoted in full, because it illustrates precisely the issues that clinical governance as understood and implemented at that time should have addressed. It is clear from Dr Tanner's letter that they had not been. These questions (and others) were turned into a media briefing pack in preparation for the publication of the

5 Department of Health, 2001. *Shifting the Balance of Power Within the NHS*. The Stationery Office.

CHI report. The responses merely sought to explain why the previous organisation had not undertaken the required actions at the time (DOH700515).

4.46 The CHI investigation report was published on 3 July 2002. CHI's conclusion was that:

> "… a number of factors … contributed to a failure of trust systems to ensure good quality patient care: 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 [which] 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 [which] meant that poor prescribing practice was not identified; and there was a lack of thorough multidisciplinary total patient assessment to determine care needs on admission." (DOH603896, p8)

4.47 The CHI report also concluded *"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"* (DOH603896, p8). Nevertheless CHI made 25 recommendations for improvement, 22 of them for the two PCTs, but observed that *"CHI does not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual"* (DOH603896, p8). On 9 January 2004, the final report of the Fareham and Gosport PCT CHI Recommendations Working Group indicated that the majority of the CHI recommendations had been implemented (DOH900666).

Chief Medical Officer response

4.48 On 16 July 2002, Professor (by then Sir) Liam Donaldson wrote a note to Marcia Fry, a senior DH official, copied to Ministers' offices and to Nigel Crisp, the DH Permanent Secretary and NHS Chief Executive. His note said that following the CHI investigation he had *"concerns that there are some aspects of the case that are still unclear [and] I believe we should consider further investigation"* (DOH000040, p2).

4.49 Sir Liam concluded:

> "I am concerned that neither the CHI investigation, nor the public investigation, nor the health authority investigation has properly examined the deaths associated with Dr Barton's practice or in relation to care of the team. I do not think that this can be left as it is, even though others appear to regard the NHS part of the investigation as concluded and are simply awaiting the GMC's verdict." (DOH000040, p5)

4.50 Sir Liam wrote to Marcia Fry again on 29 July, having met Professor Livesley, who *"believes that the police did not investigate adequately and were wrong to drop their investigation"*. Sir Liam also stated:

> "The CHI investigation did not look at individual cases … The GMC investigation may take a couple of years (on past experience) and they have not suspended the doctor concerned … Professor Livesley's report which I have seen in confidence makes worrying reading but only deals with one case. He told me that there had been mention of other cases in which death had been hastened but he had not been asked to look any more widely … Locally there is a high degree of concern amongst a number of relatives." (DOH000051, p3)

4.51 Observing that none of the previous approaches had audited the death rate or the nature of deaths systematically, the note proposed *"an NHS investigation initially examining data to look for evidence of excess mortality or clusters of deaths"*. Sir Liam proposed that he should commission for this role Professor Richard Baker, who had carried out a similar audit of deaths attributable to Harold Shipman. Recognising that this *"would clearly raise the temperature locally and nationally"*, Sir Liam said: *"he is very sound and we cannot risk a poorly conducted methodology"* (DOH000051, p4).

4.52 On 29 July, Simon Stevens, then Health Policy Adviser at 10 Downing Street, replied that it was hard to disagree with this suggestion. Mr Stevens went on to say that *"it is very worrying if in Liam's opinion the CHI investigation was inadequate, it would be helpful to have more detail on why this was, and what needs to be done in future"* (DOH000340, p1).

Re-emergence of 1991 concerns

4.53 Following receipt of Professor Baker's proposals for the review, it was launched on 13 September 2002 (DOH000032, DOH000013). On 16 September, a meeting was held in the hospital to brief staff about the review. This was led by Lucy Docherty, Chair of Fareham and Gosport PCT. While waiting for the meeting to start, a senior nurse, Toni Scammell, was approached by Staff Nurse Anita Tubbritt and Nurse Beverley Turnbull and handed a folder of documents dating from 1991/92, covering the nurses' concerns described in Chapter 1 of this Report. She realised the implications immediately: *"When I read the minutes I felt sick. I considered the minutes to be very damming."* The nurses, she said, had come to her with the material because they *"had seen an article in a Sunday newspaper about GWMH which stated that no one had ever brought their concerns about syringe drivers to the attention of management before"* (PCO000348, p3).

4.54 From the documents reviewed by the Panel, it appears that the approach made to Nurse Scammell on 16 September was the first time that healthcare organisations other than the Trust were aware of the warnings the nurses had made 11 years earlier to previous NHS managers, warnings that had gone unheeded in the intervening period.

4.55 In her note providing a diary of events for the period from 9 September to 18 September, Lucy Docherty referred to the folder of documents provided by the nurses as *"a dossier"* (LDO000019, p1). For ease of reference, the term 'nurses' dossier' is accordingly used in this Report to cover the papers handed to Nurse Scammell. Jan Peach, a service manager at the hospital, passed the nurses' dossier to Lucy Docherty. Clearly grasping its significance, she wrote: *"Intense concern and anxiety as to why we have never heard about this before"* (LDO000019, p1).

4.56 Over the next two days there was *"much debate"* between senior officers of the SHA and the Directorate of Health and Social Care (a short-lived body that succeeded the Regional Office), culminating in a decision to commission an investigation into why the information in the dossier had not emerged since 1992. At the same time the decision was taken to suspend two managers who appeared to have been involved in the 1991/92 events (LDO000019). The two were Ian Piper, now Chief Executive of Fareham and Gosport PCT, and Tony Horne, now Chief Executive of East Hampshire PCT. At the request of Lucy Docherty, their suspension was to be described as *"temporary redeployment"* (LDO000019, p2).

4.57 On 18 September, Jane Parvin, Personnel Director of Fareham and Gosport PCT, and Betty Woodland of the Royal College of Nursing (RCN) met three nurses including Toni Scammell to question them about the background to the dossier. The nurses recalled the last meeting at the

time, on 17 December 1991, as follows: *"management was one side of the room and ward staff on the other … they were put on the spot … they had not got any further, they were fed up, not supported, angry and frustrated"* (DOH700062, pp2–3). Asked whether things had changed after the meeting, they said that they had, briefly, but they *"… started again gradually … you can only be told so many times that you don't know what you are talking about"* (DOH700062, p3). They were concerned *"they would be sacked or moved … wouldn't be supported … would be named a trouble maker"* (DOH700062, p4).

4.58 It is clear from the contemporary documents that the re-emergence of the nurses' dossier prompted significant concern locally. It was also the subject of briefing to Ministers and DH officials. On 18 September, Adrian Pollitt of the Directorate of Health and Social Care South briefed that *"a number of nurses employed by Gosport PCT handed to managers of the Trust a dossier which appears to indicate that … nurses raised concerns as long ago as 1991 about high levels of prescribing of diamorphine … managers of the hospital appeared not to have taken action in a way which satisfied those nurses, despite pressure from the RCN"* (DOH000168, p1). The briefing identified the managers who might have been expected to investigate the allegations in 1991 as Mr Horne; Mr Piper, CEO of Fareham and Gosport PCT, which managed the hospital; and Mr Millett, who had been made redundant in the reorganisation which took place earlier in 2002 (DOH000168, p2).

4.59 There is a file note from Portsmouth City PCT dated the same day, 18 September 2002, which records that at around 10.00am *"the Health Authority [SHA] required PHCT Board papers to be located and secured … At 5.30 3 boxes of logged files were secured in a locked cabinet in a locked room at TCO [Trust Central Office, St James' Hospital]. Sheila Clark [CEO] has both keys"*. Below this is a manuscript note: *"Not to be destroyed or disclosed to anyone without receipt or witnesses"* (DOH602094, p2).

4.60 The note records a detailed description of the contents of each box. This shows that the boxes included all of the most important papers from Portsmouth HealthCare NHS Trust over the period 1994–2002, including Board papers, Executive Team meeting papers and Clinical Management Group meeting papers. Appended is another manuscript note, *"Box taken by R Samuel (SHA) 20 November 2002"*, signed by Mr Richard Samuel, Assistant CEO of the SHA (DOH602094, pp3–5). The Panel has found further information on the journey of these boxes (see paragraph 4.73).

4.61 The nurses' dossier was passed to CHI. In a CHI briefing note headed 'Gosport Investigation – concerns raised by nurses', and put on file on 19 September, Julie Miller, a CHI manager, said that an *"early draft of the CHI report included a short paragraph stating that concerns had been expressed by nurses to the ward sister regarding prescribing. This statement was removed by the IM in later drafts as only two nurses raised this as an issue … Additional information from nurses would not have altered the report findings or recommendations"* (CQC100008, p2). Gareth Cruddace, Chief Executive of the SHA, discussed the content of the nurses' dossier with Deputy Chief Constable Ian Readhead of Hampshire Constabulary (DOH000398, p3).

4.62 On 20 September, Dr Tanner, Director of Public Health for Hampshire and Isle of Wight SHA, wrote to Mr Cruddace, his Chief Executive:

> "The revelation that there was discussion as early as 1991 about the same allegations of poor prescribing practice, and that individuals involved are still active in local health services has only increased my sense of unease about the issue. On the face of it … we have either two isolated periods, 1991 and 1998-2001 when prescribing

practices were questionable, or possibly a period of ten years (1991-2001) when anticipatory prescribing of opiates via syringe driver was tolerated practice. This clearly requires investigation.

We have a duty, I believe, to examine the possibility of serious management and clinical collusion in obscuring details of poor clinical quality. There is a disturbing hypothesis which, in my view, must be considered, and subjected to rigorous analysis before rejection:

- There was a culture within Gosport War Memorial Hospital during the 1990s, which tolerated the prescription of opiate analgesia in inappropriate situations and inappropriately high doses
- Local medical and nursing staff were aware of this and the likely consequences to patients
- When concerns were raised by nursing staff, the managerial and clinical response was inadequate and a culture of 'doctor knows best' prevailed
- The clinical response was collusive, with a desire to 'let sleeping dogs lie'
- The emergence of complaints to the Trust in 1998 did not trigger an adequate response, because individuals were aware that a deeper analysis of the issue would potentially incriminate individuals still working in the local health system
- The response of the organisation to the police enquiries and the CHI investigation was influenced by the same considerations
- The decision taken by the Trust in March 2002, not to revisit the disciplinary investigations into involved nursing and medical staff, was partly motivated by the knowledge that their defence might include reference to formal notification of concerns dating before 1998
- The failure by the Trust to review complaints, or audit prescribing records or clinical notes relating to the period before 1997/8 was a result of the same considerations." (DOH702005, pp2–3)

4.63 There followed a large volume of email correspondence between the SHA, the PCT, the Directorate of Health and Social Care (an organisation referred to, at the time, as DHSC, which was one of four regional organisations that briefly succeeded the previous Regional Office) and the Department of Health about the nature of a management investigation and how it should be commissioned (DOH000162, LDO000003, DOH603547, DOH000329, DOH000324). In response, Sir Liam wrote to Lord Philip Hunt, Parliamentary Under-Secretary at DH, and other Ministers on 1 October 2002. This note records that the review by Professor Baker had been commissioned publicly, and that the *"intervention was not well received by the DHSC [Directorate of Health and Social Care], the Strategic Health Authority and the Primary Care Trust all of which had believed that action taken was appropriate and no further investigation was necessary. The term 'headquarters interference' was used"* (DOH000156, p2). However, the *"emergence of an old 'dossier' which may not have been robustly investigated at the time has led to a volte face by the parties involved and their insistence on the need for an independent inquiry … to determine the future of the managers who have been suspended"* (DOH000156, p3). There were three investigations taking place (by the police, Professor Baker and the GMC). Sir Liam concluded that an independent inquiry was not appropriate to deal with one strand of these investigations

(the nurses' dossier) at this stage, but an *"independent inquiry may be indicated later if the other three investigations prove the presence of untoward deaths"*. However, the *"option of sending CHI back in to look at the dossier of nursing complaints and the actions of the NHS organisations that dealt with them at the time provides an independent and statutory basis on which to take further action"* (DOH000156, p4).

4.64 Two days later, Dr Gill, Regional Director of Public Health at SERO, wrote to Marcia Fry at DH to say that *"it seems appropriate for the StHA [Hampshire and Isle of Wight Strategic Health Authority] to establish its own disciplinary process-based investigation, focussing specifically on the adequacy of the organisation's response to the expression of concerns about the quality of patient care since 1991"*. He also noted that the SHA *"should not need to make any public announcement about this fourth stream of investigatory activity"* (DOH000003, p1). Janet Walden, a DH official, wrote to Marcia Fry on the same day to say that, given that *"serious concerns appear to have been raised in 1991 … there is a prima facie case to answer for lack of appropriate management action … this in itself will need some form of independent review if public confidence is to be restored"* (DOH000155, p2).

Subsequent investigations

4.65 On 29 October 2002, Lord Hunt's Assistant Private Secretary wrote to Mr Pollitt in the Directorate of Health and Social Care South to say that Lord Hunt had discussed the proposal for a separate independent inquiry with Sir Liam, and *"agreed that an independent inquiry would not be the appropriate course of action at this time"*. Instead, *"Lord Hunt has asked that that CHI be sent back to Gosport War Memorial [Hospital] to look at the handling of the complaints which make up the nurses' dossier that recently came to light"* (DOH000151, p1).

4.66 Subsequent correspondence between Mr Samuel of the SHA and the Directorate of Health and Social Care South and DH makes it clear that the SHA was determined to press ahead with a management investigation into the handling of the 1991 nurses' concerns, and had prepared a press release. The correspondence is dated 25 November, and the response from DH points out that there was a clash with the further CHI review, as *"the final bullet point in CHI's TOR [Terms of Reference] … is, effectively, what is being proposed in the management review"* (DOH000141, p1).

4.67 On 6 December, Mr Cruddace wrote to Sir Liam confirming that the SHA and the two PCTs (East Hampshire and Fareham and Gosport) *"have commissioned an independent internal management investigation into events at Gosport War Memorial Hospital between 1988 and 1998 in order to decide whether disciplinary action should be taken in relation to senior managers and clinical managers"*. This was to be undertaken by Michael Taylor, formerly Chief Executive of Oxfordshire Health Authority, and the Terms of Reference *"have previously been … agreed with the Police"* (DOH000132, p3).

4.68 Subsequent correspondence makes it clear that Mr Taylor had already started his management investigation and was searching records (DOH603797, DOH603839). Within a week of Mr Cruddace's letter indicating that Hampshire Constabulary was aware of the Terms of Reference, the SHA's Director of Public Health, Dr Tanner, had been told that *"the chief investigating officer for the Constabulary, Det. Chief Superintendent Steve Watts was in contact to say that they now had concerns about the terms of reference of our own management investigation"* (DOH000131, p1). The SHA had placed the management investigation on hold.

4.69 The record of a meeting on 17 January 2003 (DOH603728) set out discussion between the SHA (Mr Cruddace and Mr Samuel), Fareham and Gosport PCT (Lucy Docherty, Chair), East Hampshire PCT (Margaret Scott, Chair) and a lawyer (from Beachcroft Wansbroughs). Mr Cruddace reported that at a previous meeting the *"police had indicated to the CMO [PROFESSOR DONALDSON] that … they felt that the management investigation should be suspended and that the second CHI investigation should not proceed … the CMO had agreed that the second CHI investigation would stop"* (DOH603728, p3). Following a three-hour discussion as recorded in the meeting notes, the management investigation was to be suspended and the redeployed CEOs, Mr Piper and Mr Horne, would be invited to return to their CEO positions (DOH603728, p10).

4.70 On 30 January, Sir Liam wrote to Mr Cruddace to say that the Directorate of Health and Social Care South had written to Lord Hunt on 24 January *"informing him of the decision of the Strategic Health Authority (with the agreement of the Primary Care Trusts involved) to reinstate the two NHS managers who have been redeployed pending investigations into the concerns about standards of care at Gosport War Memorial Hospital"* (DOH000124, p2). The letter made it clear that neither the SHA management investigation nor the second CHI investigation could go ahead:

> "… for the foreseeable future because the police have said that it could interfere with their own investigation … Your decision to reinstate them [the two managers] to their previous posts acknowledges the inevitability of the delay and your view that it is unfair (and possibly in breach of employment law) to continue to deny them reinstatement in the absence of information." (DOH000124, p2)

Having said that he had discussed this with Lord Hunt, Sir Liam concluded as follows:

> "Clearly this is a decision for your Authority and the Primary Care Trust as the statutory NHS bodies.
>
> We do have concerns, however, about the course of action to be taken and would ask you to assure yourselves that this is the most appropriate action bearing in mind all the circumstances.
>
> We would ask you particularly to consider the question of public confidence in local services and especially to reflect on whether your decision would be seen publicly to have had integrity in the event that at the end of the police investigation a prima facie case for wrong-doing were established." (DOH000124, pp2–3)

4.71 Mr Horne was formally reinstated as CEO on 7 February (MSC000024), and Mr Piper on 10 February (DOH700047).

4.72 Although the second CHI investigation had not started before it was placed on hold, the management investigation had completed enough work to produce an initial report (DOH702113). Mr Taylor set out the conclusions in uncompromising terms:

> "a) The failure to follow-up the expression of concerns made by nursing staff about prescribing practice in Redclyffe Annexe from 1988 was a negligent act by the Unit Management Team.
>
> b) It is unrealistic to accept that senior managers of the Unit Management Team were unaware of the concerns about prescribing practice. The main managerial responsibility for inaction following formal correspondence in 1991 appears to lie

with Mr Horne, Mr Hooper, Mrs Evans and Mr Millett. Managers seem to have placed too much reliance on the unwillingness of junior nurses to speak out in front of GPs at a meeting held on 17 December 1991 to justify any further action. If correct, this was both a naive and wholly wrong conclusion by the managers named above.

c) It is highly regrettable that the Royal College of Nursing failed to follow-up the referral of its concerns to the Community Unit and the Heath Authority in 1991. This may well have contributed to the issue 'remaining silent' until the police investigation of 1998 and the CHI investigation of 2001.

d) Clear evidence exists to demonstrate continuing concern and confusion about prescribing practice at the hospital during the years following the establishment of the Portsmouth Healthcare NHS Trust e.g. external clinical opinion in 1999. The Trust Board failed to respond to external clinical concerns about usage of opiates and initiate appropriate investigations.

e) The board of the Portsmouth Healthcare NHS Trust was assiduous in preparing formal policies and procedures. What remains unclear is:

- the degree of staff and consumer involvement in the construction of policies
- the awareness and application of the policies by the majority of clinical staff
- whether or not the policies were regularly evaluated.

f) The finding within the CHI report that the Portsmouth Healthcare NHS Trust failed to review prescribing practice following various trigger events in 1998 is strongly supported. The inevitable conclusion from this inaction is that inappropriate practice continued up to 1998. What, however, must be established is the degree to which practice at Gosport War Memorial Hospital was atypical of practice in other community hospitals. If practice was significantly different, then executive and non-executive members of the former Portsmouth Healthcare NHS Trust board should be held accountable for this failing. If it can be established that opiates were routinely prescribed in excess of conventional practice, the clinicians responsible would be culpable of professional malpractice." (DOH702113, p4)

4.73 A subsequent report produced by Mr Cruddace for the SHA (Board) on 11 February stated that the investigating team for the management investigation *"reviewed a substantial number of documents from PHCT and the former health authority [Portsmouth and South East Hampshire Health Authority]"*. The report noted that *"these documents include board minutes, executive management team minutes, various policy documents as well as a substantial number of adverse incident forms. Among this material are a number of papers that are relevant to the investigation"* (DOH703690, p4). The description of the documents closely resembles that contained in the log describing the three boxes referred to in paragraph 4.59 above. The Panel has been unable to locate these documents, despite repeated requests and investigation. Mr Samuel's recollection was that, having collected the boxes from storage, he transported them in his car to the headquarters of the SHA at Oakley Road in Southampton, where he deposited them in a locked room. He was confident that, at some subsequent point, the boxes had been passed to the police.

4.74 In addition, the Panel has received a minute of Part II of the formal meeting of the SHA held on 11 March, which also makes reference to these documents. This minute states that

"Mr Samuel tabled a Report on Investigations into the Care and Treatment of Inpatients at Gosport War Memorial Hospital". The minute goes on to say:

> "It was noted that the SHA as commissioner of the Management Investigation, would be responsible for the safe and secure storage of the paperwork. A paper will be presented to a future Part II Board Meeting on the findings to date of the Management Investigation." (DOH703750, p9)

4.75 On 21 March, Barbara Moore of the Community Hospitals Association wrote to Mr Cruddace enclosing a report which had been commissioned by Mr Taylor, titled *What Characterised Conventional Clinical and Managerial Practice in Community Hospitals during the period 1988–2000* (DOH702111). The report, based on a sample of community hospitals in three different areas, showed that clinical governance practice developed more or less in line with what was expected, including policies for prescribing and monitoring drug use.

4.76 Mr Cruddace wrote to Mr Taylor on 15 May and confirmed that the management investigation remained on hold (DOH603775). In his note to Lord Hunt and other Ministers of 1 October 2002, Sir Liam had said: *"Previous experience has shown that once a NHS investigation is halted by a Police investigation, then it can take years to start again. We cannot afford for this to happen"* (DOH000156, p3). The records show that these remarks were prescient. The management investigation would never be restarted. The second CHI investigation was never undertaken.

4.77 Following notification that the police investigation had formally concluded with no charges brought, a government lawyer from SOL (Solicitors – a government body responsible for providing legal advice) wrote to Colin Phillips, a DH official, on 18 January 2007 (DOH000285). Her note questioned what future action might be taken by the police, the Healthcare Commission (the successor to CHI) and the SHA. It also included unequivocal advice on the timing of publication of the Baker Report: *"I agree that publication should be withheld until the GMC has investigated"* (DOH000285).

4.78 Following the legal advice, Mr Phillips briefed Sir Liam on 26 January 2007 (DOH000278, p4). Hampshire Constabulary had stopped the second CHI investigation in January 2003, before it had been started; the Healthcare Commission view in 2007 was that *"unless new or different information is brought to their attention, they would not want to revisit an old CHI investigation"* (DOH000278, p5). The former SHA had placed the management investigation by Mr Taylor on hold at Hampshire Constabulary's request in January 2003; in 2007, Hampshire PCT was *"reviewing their files"* to decide whether to reinstitute an investigation led by South Central SHA, but was *"doubtful now whether reviving the old internal review serves much real purpose"* (DOH000278, p5). The question of whether a different form of investigation would be required by Article 2 of the European Convention on Human Rights was also noted.

The Baker Report

4.79 Meanwhile, Professor Baker was completing his investigation into deaths in the hospital, and he submitted his report to Sir Liam on 11 June 2003 (RBA100195). Based on a detailed analysis of 81 medical records, the report identified many important failures of clinical care (RBA100032). Professor Baker summarised his conclusions in stark terms:

> "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." (DOH000072, p4)

4.80 Professor Baker's report was passed to SOL. The subsequent legal advice was reflected in a note from Michael Evans of DH's Inquiries and Investigations Unit to Sir Liam on 30 September 2003 (DOH000073).

4.81 Mr Evans' note is significant. It considered whether the Baker Report should be published or circulated to the police, the GMC, the SHA and Dr Barton. It also considered whether the report should be circulated to Ann Alexander, who represented relatives of patients at the hospital. The note summarised the legal advice as follows:

> "SOL's advice is that:
>
> - the report is potentially damaging to Dr Barton
> - publication could therefore prejudice any criminal trial
> - even if Dr Barton is not charged then the report would be damaging to her (although not necessarily in a defamatory sense).
>
> As a result, we are advised that if publication is to be considered then this should not take place at least until the conclusion of the police investigation." (DOH000073, p2)

4.82 The note suggested that if the report were to be published, it should be published sooner rather than later, *"in order to reduce its impact on any future trial"* (DOH000073, p2). Before making such a decision, the note said, DH would also need to seek the views of the police and the Crown Prosecution Service. However, it is clear from the rest of the document that the view put to Sir Liam, reflecting the legal advice, was against publication and in favour of limited circulation.

4.83 The note then turned to the matter of who should receive copies in the interim, again closely based on the legal advice:

> "SOL's advice is that the report is of great relevance to the police and should be released to them, although we will need to seek assurances about confidentiality if you decide that the report is not to be published more generally. It is arguable that the GMC should also receive a copy from you, in confidence, to help inform any decision they may wish to make concerning patient safety. For the same reason, Dr Simon Tanner should also receive a copy to inform any decision by the SHA about Dr Barton's practice and any further action that may need to be taken locally.
>
> If you agree that the police, the GMC and Dr Tanner should receive a copy of the report then fairness would require Dr Barton to receive a copy. She would then know the foundation of any allegations based on the contents of the report. I understand that the GMC, if it receives the report, is in any event likely to want to copy it to Dr Barton at some stage so we could take the initiative and provide her with a copy of the report rather than wait for the GMC to do so." (DOH000073, p3)

4.84 Subsequent correspondence and events make it clear that Sir Liam accepted the advice to withhold publication of the Baker Report pending the completion of the police investigations. Instead copies were subsequently provided in confidence to Hampshire Constabulary, the GMC, the SHA and Dr Barton.

4.85 It is notable that throughout the correspondence and in the Baker Report, there is a tacit assumption that the underlying problem was the conduct of one doctor, Dr Barton. Earlier DH briefing suggested that concern over a potential rogue doctor prompted by the Shipman case had arisen soon after DH had become aware of the matter, in July 2001. The briefing referred to *"an uncomfortable resonance about the investigation, and I would rather that Ministers are aware of the case than find out only if it turns out that there has been serious wrongdoing"* (DOH000451, p2). It seems that this underlying concern shaped the response almost from the outset.

4.86 It is also notable that on 28 October 2002, the Gosport Medical Committee had written collectively (there were 12 signatories) to Sir Liam to raise its concern that Dr Barton was *"being used as a scapegoat"*. The letter, which was stamped as received on 10 December 2002, pointed out that Dr Barton had worked as a clinical assistant to *"approximately ten Consultant Geriatricians"* and that her *"senior colleagues were not only aware of these practices, but had similar prescribing practices"* (DOH603803, p1).

4.87 From late 2003 until 2007, there is a marked absence of relevant correspondence between the local NHS organisations, the SHA and DH about practice at the hospital. It seems that these organisations were waiting for the outcome of the police investigation. In 2006, Hampshire and Isle of Wight SHA became part of the larger South Central SHA as a consequence of national reorganisation, and the Directorate of Health and Social Care was abolished. Fareham and Gosport PCT and East Hampshire PCT became part of the larger Hampshire PCT, and Portsmouth Hospitals NHS Trust took over responsibility for inpatient services at the hospital (DOH601939, DOH601940).

4.88 Mr Phillips briefed Sir Liam on 26 January 2007 that the GMC was investigating Dr Barton and had a copy of the Baker Report (DOH000278, p4). In accordance with the legal advice from SOL, the recommendation for Sir Liam was that wider publication of the report should not be considered, *"at least until the GMC have completed their processes and Dr Barton has had a chance to comment"* (DOH000278, p5). Subsequent events make it clear that this recommendation was accepted.

4.89 In August 2007, Sir Liam responded to another briefing from Mr Phillips concerning the request from the South East Hampshire Coroner for a public inquiry rather than inquests into the deaths of some of those who had died at the hospital. Sir Liam's view, as recorded by his Assistant Private Secretary, was that DH should wait for the GMC to finish its deliberations and then see if there was a case for any further investigation by the NHS. The Assistant Private Secretary added that Sir Liam agreed *"that a full Public Inquiry is perhaps inappropriate given the safeguards now in place"* (DOH000272, p1).

4.90 Correspondence in the period between 2008 and March 2009 shows that Portsmouth Hospitals NHS Trust and Hampshire PCT were focused largely on preparations for relevant inquests (DOH602073, DOH602082, MRE000782, MRE000780, DOH603144, MRE000211, MRE001459, MRE001646, MRE001678, MRE001638, MRE001615, MRE001600). Although the correspondence refers to some relevant matters in passing, there is no evidence that consideration was given to any further investigation of previous clinical failures at the hospital or the mishandling of the nurses' concerns. The GMC and the Coroner continued to take action, and this is covered in later chapters.

4.91 At this stage, DH had not yet published the Baker Report. Mr Peter Walsh, CEO of the Association for the Victims of Medical Accidents, submitted a Freedom of Information (FOI) request for the report on behalf of the families on 6 February 2009. In 2009, Norman Lamb, then the Liberal Democrat Health Spokesman, also requested the report's release and asked for an internal review. Ann Keen, Parliamentary Under-Secretary of State for Health, responded to Mr Lamb to say that on 13 July 2009, DH's FOI Unit had responded to her saying that it considered that the exemption based on an intention of future publication (s22) applied. Since then, Ann Keen said, DH had learned that the Coroner intended to hold another inquest into a death at the hospital, but that a date had not been set. In addition, there was a continuing GMC hearing into Dr Barton's fitness to practise. Given these facts, DH now considered that s31 (under which public authorities are not obliged to release information likely to prejudice the functions of law enforcement) applied, since the report's release could be prejudicial to the administration of justice.

4.92 The final inquest was held in April 2013. Gerard Hetherington, the senior DH official now dealing with publication of the Baker Report, emailed Marjorie Palmer in the DH NHS Business Unit on 22 April 2013 to say that this did not necessarily mean the report could be published, since according to DH Legal Services there were issues relating to data protection (DOH104068). This meant that Dr Barton should be given the opportunity to review the report first. Mr Hetherington's submission of 29 July expanded on these issues further, stating that DH had to consider under data protection legislation whether there had been any undertakings of confidentiality about personal data in the report. Professor Baker was contacted; he said that he had not given any such undertakings but, while he had not interviewed Dr Barton, he recommended that she should be given an opportunity to review the report and comment (DOH103593, p5).

4.93 Accordingly, DH sought Dr Barton's address, and she was contacted on 27 June through her solicitor, Ian Barker. Dr Barton replied on 4 July through her solicitor that she was not asking for the removal of any content in the report. At this stage, s22 (the future publication exemption) was claimed in response to ongoing FOI requests (for example, RBA100213).

4.94 An official in the DH FOI team sought the advice of DH Legal Services and, on 24 July, a government lawyer advised the official that using s22 of the FOI Act as a reason for not releasing the report was becoming untenable, with no date for publication set (DOH104057). The official in the FOI team emailed Mr Hetherington to say that he also thought publication could not be delayed, and asked for a submission to Ministers to be expedited (this appears to have been previously discussed). He further said that if DH could not find a specific date that counted as a *"reasonable interval"*, then DH Legal Services' advice was that the report should be published as a matter of urgency. Otherwise, DH ran the risk of the Information Commissioner's Office ordering it to release the report, and publishing that order on its website (DOH104057). The Panel has asked the Information Commissioner's Office if it has a record of any material relating to this, but it has not found anything. On 25 July, the official in the FOI team and the government lawyer again asked Mr Hetherington for the submission to be sent to Ministers, recommending publication of the report within seven days (DOH104065).

4.95 Mr Hetherington sent the submission (widely copied) to Earl Howe as Duty Minister on 29 July (DOH103690). He attached a copy of the Baker Report. There was no mention of Mr Lamb's previous interest in the submission, despite the fact that he was now Minister of State at DH. Earl Howe agreed that the report should be published immediately (DOH103676, p7). It was published on 2 August.

4.96 Following publication, DH considered whether any further action should be taken in respect of the events at the hospital. This led to the consideration of whether a public inquiry, or a Hillsborough-type panel, should be established. This is explained further in Chapter 11 of this Report.

Conclusion: what is added to public understanding

- In 1998, a complaint was made about the treatment of Mrs Richards, who died on 21 August 1998. The investigation report shows that William (Bill) Hooper commissioned the investigation. The investigation report included reference to medication administered via a syringe driver, but this was not identified as one of the questions raised by the complaint, and the report did not identify the contents of the syringe driver (diamorphine, midazolam, hyoscine and haloperidol). Mr Hooper, who commissioned and presumably received the report, was one of the managers involved in the response to the nurses' concerns over opioid use six years previously.

- An internal briefing was produced within the Department of Health on 5 April 2001, following local press coverage. The briefing identifies factors common to three complaints, including the responsible consultant and the clinical assistant. It concludes that *"there is not sufficient evidence, at this time, to suggest that these deaths are linked or are the result of foulplay"*.

- There is no documentary evidence that either the Health Authority or the Trust, or their successor organisations, conducted any systematic investigation of these events.

- On 16 July 2002, Sir Liam Donaldson briefed senior officials and Ministers that, following the Commission for Health Improvement investigation, he had *"concerns that there are some aspects of the case that are still unclear [and] I believe we should consider further investigation"*. He proposed that Professor Richard Baker should conduct *"an NHS investigation initially examining data to look for evidence of excess mortality or clusters of deaths"*.

- On 16 September 2002, a meeting was held in the hospital to brief staff about Professor Baker's review. This was led by Lucy Docherty, Chair of Fareham and Gosport Primary Care Trust. While waiting for the meeting to start, a senior nurse, Toni Scammell, was approached by Staff Nurse Anita Tubbritt and Nurse Beverley Turnbull and handed a folder of documents dating from 1991/92, covering the nurses' concerns described in Chapter 1 of this Report. She realised the implications immediately: *"When I read the minutes I felt sick. I considered the minutes to be very damming".*

- From the documents reviewed by the Panel, it appears that the approach made to Nurse Scammell on 16 September 2002 was the first time that healthcare organisations other than the Trust were aware of the warnings the nurses had made 11 years earlier to previous NHS managers, warnings that had gone unheeded in the intervening period.

- Over the next two days there was *"much debate"* between senior officers of the Strategic Health Authority and the Directorate of Health and Social Care (a short-lived body that succeeded the Regional Office), culminating in a decision to commission an investigation into why the information in the dossier had not emerged since 1992. At the same time the decision was taken to suspend two managers who appeared to have been involved in the 1991/92 events. The two were Ian Piper, now Chief Executive of Fareham and Gosport

Primary Care Trust, and Tony Horne, now Chief Executive of East Hampshire Primary Care Trust.

- The note records a detailed description of the contents of each box. This shows that the boxes included all of the most important papers from Portsmouth HealthCare NHS Trust over the period 1994–2002, including Board papers, Executive Team meeting papers and Clinical Management Group meeting papers. Appended is another manuscript note, *"Box taken by R Samuel (SHA) 20 November 2002"*, signed by Mr Richard Samuel, Assistant Chief Executive Officer of the Strategic Health Authority. The Strategic Health Authority, when reviewing the subsequent management investigation, described these boxes, which are missing from the material made available to the Panel, as including *"a number of papers that are relevant to the investigation".*

- On 6 December 2002, Gareth Cruddace wrote to Sir Liam confirming that the Strategic Health Authority and the two Primary Care Trusts (East Hampshire and Fareham and Gosport) *"have commissioned an independent internal management investigation into events at Gosport War Memorial Hospital between 1988 and 1998 in order to decide whether disciplinary action should be taken in relation to senior managers and clinical managers"*. This was to be undertaken by Michael Taylor, formerly Chief Executive of Oxfordshire Health Authority, and the Terms of Reference *"have previously been … agreed with the Police"*.

- The record of a meeting on 17 January 2003 states that *"the management investigation should be suspended and that the second CHI investigation should not proceed … the CMO had agreed that the second CHI investigation would stop"*. Following a three-hour discussion as recorded in the meeting notes, the management investigation was to be suspended and the redeployed Chief Executive Officers, Mr Piper and Mr Horne, would be invited to return to their Chief Executive Officer positions.

- Although the second Commission for Health Improvement investigation had not started before it was placed on hold, the management investigation had completed enough work to produce an initial report. Mr Taylor set out the conclusions in uncompromising terms.

- While the management investigation remained on hold, Sir Liam had said on 1 October 2002: *"Previous experience has shown that once a NHS investigation is halted by a Police investigation, then it can take years to start again. We cannot afford for this to happen."* The records show that these remarks were prescient. The management investigation would never be restarted. The second Commission for Health Improvement investigation was never undertaken.

- The records show that the Department of Health used a number of different Freedom of Information Act exemptions to resist publication of the Baker Report until legal advice was received in July 2013 that it should be published.

Chapter 5: Hampshire Constabulary and the Crown Prosecution Service

Introduction

5.1 The nurses' concerns about the prescribing and administering of drugs at Gosport War Memorial Hospital ('the hospital') are described in Chapter 1 of this Report. The Panel has found no documents indicating that Hampshire Constabulary, the relevant police force, was made aware of these concerns. Nor do the papers show any approach to Hampshire Constabulary in the period up to 1998.

5.2 Between 1998 and 2010, Hampshire Constabulary conducted three investigations and engaged with the Crown Prosecution Service (CPS). This chapter explains what the documents reveal about those investigations and the relevant actions of the CPS. The chapter concludes by examining corporate liability and health and safety offences, the relationship between the police and the CPS, and how the complaints against the police were handled.

First police investigation

5.3 In order to understand the beginning of the first police investigation, it is necessary to set out how the family of Gladys Richards viewed her treatment and the circumstances of her death at the hospital. On 29 July 1998, Mrs Richards, a 91-year-old resident of the Glen Heathers Nursing Home situated in Lee-on-the-Solent, Hampshire, had fallen and sustained a right fractured neck of femur. She had been admitted to the Royal Hospital Haslar ('Haslar Hospital'), where she underwent implantation of an artificial hip joint.

5.4 On 20 August, Lesley Lack, Mrs Richards' daughter, made a verbal complaint to Lesley Humphrey, Director of Quality at the Portsmouth HealthCare NHS Trust, about the poor standard of care that had been provided to her mother (RCN000013, p1).

5.5 Mrs Richards died on 21 August. On 24 August, Dr Jane Barton, clinical assistant at the hospital, reported Mrs Richards' death to the Coroner and the cause of death was stated to be bronchopneumonia (HCO500071, p1).

5.6 Chapter 4 describes the steps taken by the Trust following Mrs Richards' death. This chapter explains how the action taken by Mrs Richards' daughters, Lesley Lack and Gillian Mackenzie, prompted the investigation by Hampshire Constabulary.

5.7 On 27 September 1998, Mrs Mackenzie telephoned Gosport Police Station. She spoke with Detective Constable (Det Con) Nick Bettesworth and alleged that her mother had been unlawfully killed at the hospital. Det Con Bettesworth made a note of the complaint on a 'Hampshire Constabulary Message Form', which was later sent to Detective Inspector (Det Insp)

Stephanie Morgan, one of the police officers who would become part of the resulting police investigation (HCO001036, pp18–19).

5.8 In the Message Form, Det Con Bettesworth recorded a number of additional concerns that had been raised by Mrs Mackenzie, including: that her mother's cause of death had been wrongly recorded on the death certificate; that a hospital investigation into the death had taken place; that there had already been a degree of liability admitted by the hospital; that the subsequent response from the hospital referred to conversations that had not taken place; and that Mrs Mackenzie felt that there was a cover-up by the NHS (HCO001036, pp18–19).

5.9 The Message Form records that Mrs Mackenzie was not willing to provide Det Con Bettesworth with the details and had insisted that she wished to speak to the head of Gosport Criminal Investigation Department (CID). On the form, Det Con Bettesworth expressed the view that the case seemed to fall short of unlawful killing, that this might be a case of negligence and that it was, therefore, a matter for the General Medical Council (GMC). Referring to Mrs Mackenzie, Det Con Bettesworth also wrote that *"she appears on the phone to be 'copus mentus' (normal) but obviously we only have her word with regards to the ins and outs of the incidents and what she claims to be in this report"* (HCO001036, pp18–19).

5.10 The documents do not make clear the basis on which Det Con Bettesworth made these comments. Their tone would prove to be an example of the mindset of the police throughout this investigation, as disclosed by the documents reviewed by the Panel. There is no record of any investigative, evidential or reasoned basis for forming the view that the case seemed to fall short of unlawful killing at this stage. In a later statement, Mrs Mackenzie said that Det Con Bettesworth's attitude gave her the impression that he regarded her as emotional and that he was *"dismissive"* of her request (HCO501762, p2).

5.11 Det Con Bettesworth confirmed that he had informed Mrs Mackenzie that he would take advice, make some preliminary enquiries and that someone would get back to her. The note to Det Insp Morgan ends *"over to you"* (HCO001036, p19).

5.12 On 2 October 1998, Detective Constable (Det Con) Richard (Dick) Maddison, who was appointed as the Investigating Officer, met with the sisters Mrs Mackenzie and Mrs Lack at Gosport Police Station. In a later statement, Mrs Mackenzie recalled that during this meeting both of them outlined the nature of their concerns to Det Con Maddison, who in turn expressed the view that it was not a police matter and that they should contact the GMC (HCO501762, pp3–4).

5.13 It would appear that Det Con Maddison spoke with Nurse Philip Beed, Clinical Manager. In a later statement, Mrs Mackenzie recalled that Det Con Maddison informed her that he had *"had a conversation with the managing nurse who he said was called Philip"* who had informed Det Con Maddison that Mrs Richards' treatment had been explained to her daughters and that they had agreed with it (HCO501762, p5).

5.14 On 5 October, Det Con Maddison submitted a two-page report to Det Insp Morgan (HCO001036, pp1–2). The report was accompanied by copies of the notes made by Mrs Lack regarding her mother's care at Glen Heathers Nursing Home and at Gosport War Memorial Hospital (HCO001036, pp3–16), together with a copy of the response to her complaint by Max Millett, the Chief Executive of Portsmouth HealthCare NHS Trust. Det Con Maddison summarised the nature of the complaint to be:

- inaccurate death certificate
- false conversations referred to in Mr Millett's response
- unlawful killing of Mrs Richards by Dr Barton, by omission of a nourishment/liquid drip, thus bringing about her premature death.

5.15 Mrs Lack's notes and Det Con Maddison's report (HCO001036, pp1–16) set out that:

- On admission to the hospital, Mrs Richards was able to walk, was pain free and no analgesia was necessary at that time.
- On admission to the hospital, Mrs Richards' dementia-related anxiety had been misread as pain and she had been given morphine oral solution, which had affected the ability to give her fluids. In relation to this point Mrs Lack made the note *"knocked off"*.
- Mrs Richards had suffered a fall and a dislocated hip, and there had been a failure by the staff to appreciate that she had been injured and was in pain. She had also suffered a failure by nursing staff and doctors to carry out an examination, a delayed X-ray and, therefore, a consequent delayed referral back to Haslar Hospital.
- Haslar Hospital had administered an epidural, had carried out a manipulation of the dislocation and had provided Mrs Richards with fluids.
- Mrs Richards again recovered in Haslar Hospital and had returned to a pain-free condition, was using a commode, was able to stand and get out of bed and was eating and drinking before being returned to Gosport War Memorial Hospital.
- There were concerns around the manner of Mrs Richards' transfer back to Gosport War Memorial Hospital, and the position in which her right leg had been left when she was returned to her bed on Daedalus Ward.
- Mrs Richards was found to be in pain due to the position in which her leg had been left.
- This pain had initially been treated with morphine oral solution, but once the leg was moved to a more comfortable position she no longer seemed to be in pain.
- An X-ray was carried out and confirmed that there was no dislocation and Mrs Richards continued to be treated with morphine oral solution.
- Subsequently, a large haematoma in the top of the right leg was diagnosed by Dr Barton as causing the pain.
- The use of a syringe driver was explained by Dr Barton as the kindest way to treat Mrs Richards. Dr Barton also said *"and the next thing will be a chest infection"*.
- Mrs Lack and Mrs Mackenzie agreed with the use of the syringe driver, the outcome of which was fully explained to them.
- From the commencement of the syringe driver to the day of her death, Mrs Richards received nil by mouth and did not have a drip, which would have given her nourishment and fluid.
- From Wednesday 19 August until Friday 21 August, Mrs Richards was not seen by any doctor.
- Mrs Richards' daughters queried the cause of death recorded on the death certificate as the doctor did not attend their mother during the final days of her life.

5.16 In his response (HCO001036, pp22–5), Mr Millett dealt only with the questions asked by Mrs Lack in her notes and confirmed that:

- Mrs Richards' dislocation could have been identified earlier.

- The delay in obtaining an X-ray was a consequence of the failure to identify the dislocation earlier and due to the opening hours of the X-ray department.
- Mrs Richards had shown signs of being in pain as she was put in the ambulance at Haslar Hospital.
- Dr Barton felt that the surgical intervention necessary to treat the haematoma would have required a general anaesthetic, which Mrs Richards was not well enough to undergo and, therefore, the only option was to keep her pain free and allow her to die peacefully, with dignity.

5.17 Mr Millett's response did not refer to the report prepared by Sue Hutchings, Nursing Coordinator, referred to in Chapter 4.

5.18 Det Con Maddison concluded that there had *"been a great deal of neglect, and miss treatment"* of Mrs Richards, which had been accepted by the hospital. However, he also felt that an inconsistency between the accounts of Mrs Mackenzie and Mrs Lack with regard to a conversation with hospital staff about the treatment of their mother was an obstacle to prosecution and that, if the sisters wished to pursue the matter further, they should refer it to the GMC. The central issue to be investigated was the appropriateness of the treatment and care given to Mrs Richards, and not any question of the family's knowledge or agreement (HCO001036, p2).

5.19 The documentation available to the Panel shows the action taken by the police to assess the validity of the concerns being raised by Mrs Mackenzie and Mrs Lack. The report by Det Con Maddison consisted of a reiteration of the notes taken by Mrs Lack. Det Con Maddison did not: (i) identify any potential witnesses; (ii) take any statements; (iii) make contact with the hospital to secure medical notes, records or evidence, or Lesley Humphrey's report which contained early accounts from nursing staff; (iv) undertake a scene visit; (v) consider any forensic evidence; or (vi) give any thought to the possibility of looking into other patient records for similar issues. In addition, he did not take any investigative steps to secure best evidence. This was particularly important given that Mrs Richards had been cremated and therefore could not be the subject of a post mortem and toxicology report. There was also no attempt to seek advice from the CPS.

5.20 The Panel has seen no documents to suggest that Det Con Maddison took any formal steps to refer the matter to the GMC.

5.21 In his report, Det Con Maddison confirmed that he had requested that research be started at the library (CPS001658, p2). On 15 October 1998, Adrian Dadd, a police sergeant in the training department who was often called upon to undertake research in matters of law, provided a note to Det Con Maddison. Sgt Dadd said that the only offence that seemed to be a possibility was manslaughter (CPS001657). He set out the basic elements of gross negligence manslaughter and concluded:

> "From what little I know of the circumstances surrounding the case you are dealing with it seems unlikely that manslaughter would be appropriate for the following reasons: 1. The 'neglect' was more of a corporate issue than individual to one particular person. 2. The death occurred for a number of reasons and was not the direct and immediate result of 'neglect'. 3. Were the actions of the hospital staff gross negligence or merely inadvertence? From what you have said it seems to be the latter which would be insufficient for manslaughter …" (CPS001657, p1)

5.22 Between 5 October and 20 October, Det Con Maddison's report was passed between a number of senior police officers for consideration and each provided comment.

5.23 The report was first sent to Detective Sergeant (Det Sgt) Nigel Oliver (CPS001642). In a covering note, Det Con Maddison wrote, *"I have no idea why these two sisters are so out to stir up trouble"*, and suggested that it might be because they felt *"uncomfortable about not nursing their mother"* (p1). He observed that there was a general acceptability of the use of a syringe driver to relieve pain, that a drip was a nuisance which inhibits the ability to provide care and that a drip would make no difference as *"an elderly person can go a few days (5) without the need for fluid, most survive on a cup of tea a day and when in bed not moving it becomes less necessary … using diamorphine by making the patient more comfortable can increase the life expectation, it is not any form of euthanasia"* (p1). He concluded that there had been a breakdown in communication between Dr Barton and Mrs Richards' daughters and asked whether he should seek advice from a police surgeon or the Macmillan Trust (p1).

5.24 The documents reveal the mindset of the police: within 11 days of their approach to Hampshire Constabulary the family of Mrs Richards were effectively described as troublemakers.

5.25 In turn, Det Sgt Oliver referred the report to Det Insp Morgan. In his cover note (date-stamped 8 October 1998), Det Sgt Oliver expressed the view that there was no case for further investigation. This was based on his view that Mrs Richards' daughters were consulted about the treatment to be provided to their mother and the likely effect of the syringe driver. Det Sgt Oliver concluded that the decision to use a syringe driver was a calculated medical decision made following the discovery of the haematoma (although there was no evidence in the medical records of this), and this appears to have been his rationale for no further investigation (CPS001642, p2).

5.26 Det Insp Morgan then referred the report to Detective Superintendent (Det Supt) Mike Lane. In her covering note, Det Insp Morgan acknowledged a *"seemingly atrocious lack of care in relation to the deceased"*. She went on, however, to concur with Det Sgt Oliver and expressed the view that there would be *"considerable difficulties"* proving that the *"careless acts"* had caused Mrs Richards' death (CPS001642, p2).

5.27 In his response to Det Insp Morgan (date-stamped 16 October 1998), Det Supt Lane confirmed that the only criminal issue was the question of whether Dr Barton's use of a syringe driver without a drip was appropriate or whether it had led to the death of Mrs Richards and constituted gross negligence. Det Supt Lane advised that the decision would rest with the CPS which could only make that decision once expert medical opinion had been obtained. Det Supt Lane directed that the options for obtaining appropriate medical opinion should be explored, the case should be submitted to the CPS and the family should be kept informed (CPS001642, p3).

5.28 Det Insp Morgan asked Det Sgt Oliver to instruct Det Con Maddison to obtain expert medical evidence (date-stamped 20 October 1998) (CPS001642, p3). The documents suggest that, rather than consulting a relevant expert, Det Con Maddison sought a statement from a Macmillan nurse on the use of palliative care. The resulting one-page statement dealt with palliative care generally and had no application to Mrs Richards' case (HCO007012, p1).

5.29 By 2 October 1998, the first evidence file had been passed from Det Con Maddison to the local CPS. The note accompanying the file did not set out any evidence and it is not clear precisely what material was provided to the CPS for consideration. The note to the CPS described the accusation as *"death being caused by a doctor failing to give liquid by way of a*

drip" and stated: *"my enquiries have found that this is not a necessary procedure. The doctor fully explained the procedure of placing a syringe driver in place and the eventual outcome. This is admitted in the notes made"* (CPS001641, p1).

5.30 On 20 November, Mrs Mackenzie complained to Sir John Hoddinott, the then Chief Constable of Hampshire Constabulary, that on 5 November Det Insp Morgan had spoken to her in an aggressive, uncivil and unprofessional manner and that she had passed the investigation file to the CPS prematurely given the lack of investigative steps. Mrs Mackenzie also complained that Det Con Maddison had not properly investigated her complaint regarding Mrs Richards' death (HCO501782). This complaint was acknowledged on 10 December by Chief Superintendent (Ch Supt) David Basson, Head of the Professional Standards Department (PSD) (HCO501781).

5.31 On 24 November, the local CPS returned the file to Hampshire Constabulary and advised that there was insufficient evidence for a prosecution. The CPS's view was that the Macmillan nurse's statement was of no use and that there was a need for *"properly qualified medical evidence"*. The concerns *"if investigated and backed up with medical evidence, could suggest such recklessness and neglect as to enable [the prosecutor] to consider further the possibility of proceeding against Dr Barton (or another or others of the Hospital staff) for manslaughter"* (HCO007009, p2).

5.32 Given the CPS advice that further investigative action was necessary, the investigation into Mrs Mackenzie's complaint about the conduct of Det Insp Morgan and Det Con Maddison was temporarily suspended pending the completion of the investigation (HCO501779).

5.33 The documents show how Det Con Maddison chose to interpret the need for *"properly qualified medical evidence"* as identified by the CPS. On 11 December, he rang Lesley Humphrey, who made a handwritten file note of their conversation. The file note says that Det Con Maddison had informed her that Mrs Mackenzie had asked the police to bring a charge of *"unlawful killing"* against the doctor in charge of Mrs Richards' care. Det Con Maddison described the allegation as being that the doctor had failed to provide nourishment via a drip while a syringe driver was being used, thereby causing Mrs Richards' death. Det Con Maddison added that he had already spoken with a Macmillan nurse who took the view that the drip was probably not used as it would have caused added discomfort. Det Con Maddison stated that he needed to decide what action to take, and that he felt it was not a police matter because it was about a clinical decision. The file note also records that Det Con Maddison requested that the hospital provide a statement and a copy of the medical records dealing with the use of syringe driver, IV fluids, decisions made and why, and the details of information that was shared with the family. Det Con Maddison said that he *"had been in contact with the GMC who have asked him to write to them explaining that charge comes from Mrs Mackenzie and not police"* (SOH900117, pp42–4).

5.34 The same file note records Lesley Humphrey as saying *"we would do our best to help – be consulting our solicitors – get back to him next week"* and lists these actions:

> "1) Get notes from GWMH [Gosport War Memorial Hospital] to check details.
>
> 2) Check with Solicitors about NOK [next of kin] consent etc.
>
> 3) ? Seek consent from Mrs Lack & Mrs Mackenzie (?NOK) to give info to police – copy to police.
>
> 4) Alert Dr concerned (Dr Jane Barton GWMH Sultan Ward).
>
> 5) Check info to be given to police with solicitor." (SOH900117, pp42–4)

5.35 The file note shows that neither Hampshire Constabulary nor the Trust recognised the shortcomings of providing *"properly qualified medical evidence"* from within the hospital. There had already been a reference to possible corporate culpability in Sgt Dadd's note of 15 October 1998. Despite this reference, Det Con Maddison's approach led to the police relying on the hospital and its consultant, who were both potential defendants, to provide the crucial and determinative evidence in the case. This led to a complete failure by the police to secure any evidence relating to corporate conduct. Such information might have included documents and witness statements relating to the concerns that had been raised by nurses and the Royal College of Nursing in 1991. This in turn led to the Trust acting in a way that had the potential to seriously undermine the investigation and integrity of evidence.

5.36 Lesley Humphrey thought it appropriate to *"alert"* Dr Barton to the police investigation. This had the potential to undermine the investigation (SOH900117, pp42–4).

5.37 The Panel also notes that William (Bill) Hooper, the General Manager for the hospital, was informed about the police investigation and agreed with the action suggested (SOH900117, p44).

5.38 Six days after Det Con Maddison's phone call, on 17 December, Lesley Humphrey sent a memo to Dr Althea Lord, a consultant geriatrician at the hospital and responsible for Dr Barton, requesting that Dr Lord provide a statement to the police. The memo dictated the issues to be covered by Dr Lord and confirmed that the Trust's solicitor would be asked to comment on the content of the statement before it would be sent to the police. In this regard, Lesley Humphrey wrote *"once we are all comfortable with the content we will forward to the police"* (CPS001557, p1). The Panel has seen no documents to confirm what response was received from the Trust's solicitor and whether or not any advice was received or any amendments were made to the statement.

5.39 On the same day, 17 December, Det Con Maddison wrote to Mrs Mackenzie stating:

> "I have now received advice, from the Crown Prosecution Service regarding the death of your mother at Gosport War Memorial Hospital. They have advised that expert opinion should be sought from the General Medical Council. In order to gain the advice, I have approached Portsmouth Health Care Trust to obtain your mothers hospital notes. I understand that they may write to you for your permission to release them. At the present time I am unable to approach any of the staff, at the hospital as they would need to be interviewed on tape and under caution." (HCO007008, p1)

The records show that Det Con Maddison had in fact approached the staff and that they had not been interviewed on tape and under caution.

5.40 On 22 December, five days after Lesley Humphrey's memo, Dr Lord provided a two-page statement which dealt with three issues: (i) the use of diamorphine via syringe driver; (ii) the decision not to start intravenous fluids; and (iii) what was agreed with Mrs Mackenzie and Mrs Lack (HCO500062, pp2–3).

5.41 In her statement, Dr Lord said that on 17 August 1998, when Mrs Richards returned from Haslar Hospital to Gosport War Memorial Hospital for the final time, she was in severe pain and was administered morphine oral solution. Mrs Richards was then placed on a syringe driver through which diamorphine, haloperidol and midazolam were administered continuously. This analgesia and sedation was considered necessary to keep Mrs Richards comfortable and aimed at addressing pain, anxiety and agitation. Mrs Richards was being provided with palliative care

and, Dr Lord said, in this instance, fluids were often not used as they do not significantly alter the outcome (HCO500062, pp2–3).

5.42 Dr Lord also confirmed in her statement that any patient requiring intravenous fluids would need to be transferred to Haslar Hospital and that, owing to her age and fragility, such a transfer in the case of Mrs Richards would not have been appropriate. Dr Lord specifically pointed out that the concern around this was not raised by Mrs Richards' daughters on the ward or in Mrs Lack's notes that were sent to Lesley Humphrey. The statement concluded with an assertion that Nurse Beed discussed the use of morphine oral solution and diamorphine via syringe driver with Mrs Richards' daughters, who agreed with such a course of action. Dr Lord did not raise any concern or criticism of the care that had been provided (CPS001705).

5.43 On 23 December, Dr Lord faxed her statement, along with a letter, to Lesley Humphrey. Dr Lord highlighted a number of issues with the content of the investigation report, which had been prepared by Mrs Hutchings (NHE000704). Dr Lord's correspondence was copied to Mr Hooper, and also to Barbara Robinson (Service Manager) and Nicky Pendleton (General Manager). With regard to Mrs Hutchings referencing an agreed policy that patients would not be transferred to accident and emergency X-ray departments outside working hours, Dr Lord wrote:

> "This statement is false. I am the sole member of the medical consultant team for NHS Continuing Care at GWMH at present. Neither I or any of my predecessors have recommended such a policy. There is no written policy regarding transfer of patients to A & E at Haslar. If there is one as mentioned I would be grateful for a copy as I have not been able to find one either at QAH [Queen Alexandra Hospital] or Gosport. It is expected that anyone suspected of a fracture or dislocation is sent to the nearest A & E department and if there is a reason for not doing so this is documented in the notes." (NHE000704, p6)

5.44 Dr Lord highlighted that neither she nor the duty consultant geriatrician had been involved in the decision not to transfer Mrs Richards on the night of 13 August 1998. Dr Lord also confirmed that, on 20 December, she had issued guidance to the wards, under the supervision of Dr Barton and Dr Anthony Knapman, who also worked at Dr Barton's GP practice and provided clinical assistant cover for Dr Barton, on what should be done if such circumstances arose again (NHE000704, p6 and p9).

5.45 Dr Lord also highlighted that she had not been consulted about Mrs Lack's complaint. She wrote:

> "Further I was not consulted about this complaint in August or September. In spite of a statement that is an insult to my professional integrity I find out by chance on the 18th December – more than 3 months after it was written. Why?" (NHE000704, p6)

Dr Lord requested that the process of dealing with complaints at the hospital be brought into line with the process at Queen Alexandra Hospital so that any complaint would be copied to her for a response and the final report would be provided to her before being sent to the complainant (NHE000704, p6).

5.46 On the following day, 23 December, Lesley Humphrey responded:

> "Thanks for your fax – your statement looks ideal. I'll ask our solicitors to look at it before forwarding to the Police. With regard to your two comments, I fully agree that these issues need resolving and I will work with Nicky Bill and Barbara to sort

> things out. Thank you for your help – sorry for the added stress all this has caused." (NHE000703, p1)

5.47 Lesley Humphrey also sent an email to Mr Hooper, Barbara Robinson and Nicky Pendleton, in which she stated: *"… with regard to the statement for the police I'll get our solicitors to cast an eye over it before forwarding to the police with a covering letter from Max (looks excellent to me) and I've told Althea this"* (NHE000703, p3).

5.48 On 19 January 1999, Mr Millett wrote to Det Con Maddison and provided Dr Lord's statement. In his covering letter, Mr Millett said:

> "You will see from Dr. Lord's report that the use of a syringe-driver was discussed with Mrs. Richards' daughters, Mrs. Lack and Mrs. McKenzie. The administration of intravenous fluids was not raised by either daughter prior to Mrs. Richards' death, or in the subsequent formal complaint. The care provided was appropriate for Mrs. Richards' needs. Strictly speaking the complaint was never formally concluded. Our offer to meet with both daughters to discuss their concerns was accepted and arrangements were made for this to take place on 29th October, 1998. Mrs. McKenzie then advised us that this date was not convenient and volunteered to agree a suitable date with her sister and inform us accordingly. This action was agreed on 30th September, 1998; we heard nothing further until your call to Mrs. Humphrey on 11th December, 1998." (CPS001650, p1)

5.49 The documents available to the Panel show that Mr Millett's letter to the police and Dr Lord's statement were silently shared with Dr Barton, Mr Hooper and Dr Lord. This would not have been apparent to the police at the time (NHE000702, p1). Chapter 1 shows that Mr Hooper and Mr Millett had been made aware of the nurses' concerns in December 1991 or January 1992.

5.50 On 1 February 1999, Det Con Maddison provided Dr Lord's statement to Det Insp Morgan, with a cover note in which he again expressed the view that no further investigation should be carried out (HCO006998, p6). On 2 February, Det Insp Morgan passed the file back to Robert Wheeler, prosecutor at the local CPS, for consideration. The cover note, from Det Insp Morgan to Mr Wheeler, states:

> "… further evidence has been obtained … from Dr A Lord, a Consultant Geriatrician. He [sic] is an independent in relation to this matter in that he had nothing to do with Mrs Richards treatment. He is eminently well qualified to give an expert opinion in this case … Again it would appear that this decision was taken for sound medical reasons as opposed to any wish on the Doctors part commit euthanasia relation to Mrs Richard's." (HCO006998, p7)

Det Insp Morgan's note ends by stating that Mrs Mackenzie and Mrs Lack were consulted about the decision to omit intravenous feeding and that there was no evidence that would suggest negligence in this case and enable a successful prosecution for manslaughter.

5.51 On 11 March, Mr Wheeler responded in a short letter, which simply said: *"In light of all the material provided, I do not consider there is evidence to justify a prosecution of the medical staff involved in the care of Mrs Richards for manslaughter, or any other criminal offence"* (CPS001645, p1).

5.52 On 17 March, Det Insp Morgan wrote to Mrs Mackenzie to inform her of the CPS decision not to prosecute any of the medical staff involved in the care of Mrs Richards. That marked the end of this investigation (HCO500056).

5.53 There is nothing in the records to suggest that either the police or the CPS considered the need to instruct Counsel for advice or reflected upon the inadequacy of this investigation and the conflict of Dr Lord. Nor is there any reference to the Code for Crown Prosecutors. The documents suggest that no consideration was given to the range of potential offences and defendants or to the possibility that there were other similar cases at the hospital.

5.54 The conclusion of the first police investigation meant that Mrs Mackenzie's complaint about the conduct of Det Con Maddison and Det Insp Morgan could be further investigated. On 16 August 1999, Detective Superintendent (Det Supt) Andrew Longman produced a highly critical report in relation to Det Con Maddison's investigation. Among the criticisms were:

- "The seriousness of the allegations warranted … overall responsibility for the investigation [to be] taken by the Detective Inspector as Senior Investigating Officer, the use of a Policy Book to record the decision-making processes and the use of a simple action based paper system to administer the enquiries."
- "Statements should have been obtained at an early stage from both Mrs. McKenzie and Mrs. Lack outlining their allegations and concerns."
- "Mrs. Lack's detailed notes should have been produced correctly with a proper explanation on how, when and where the notes were compiled."
- "Early efforts should have been made to secure and produce the relevant hospital notes. It is not clear if these have ever been in police possession."
- "Opinion should then have been obtained from an independent medical expert preferably in addition to the report obtained from Dr. Lord who has strong connections to Gosport Memorial Hospital." (Det Insp Morgan had accepted that Dr Lord was not independent; HCO502128, p17)
- "This independent statement ideally should have contained best practice procedures in this sort of case together with a comparison of the treatment received by Mrs. Richards as recorded on her hospital notes commenting specifically on the lack of intravenous fluids during the period of syringe driver pain killing medication prior to her death."
- "In my view, an interview should then have been arranged by appointment with Dr. Barton under caution where her response to the allegations should have been sought."
- "… in this case the allegation is one of 'unlawful killing' and it deserved the professional approach that clear ownership by a Senior Investigating Officer and the utilisation of simple systems would have afforded. This would have ensured the integrity of the process and subsequent scrutiny." (HCO000635, pp14–15)

This investigation continued until early 2001 when the Police Complaints Authority (PCA) reached a decision on the complaint and both officers were issued with advice and guidance (HCO501746, p1).

5.55 Documents seen by the Panel include accounts by Charles Stewart-Farthing (IMI000466, pp2–3), who stated that, following the death of his stepfather Arthur Cunningham at the hospital on 26 September 1998, he made a complaint to Mr Millett on 2 October 1998. Mr Stewart-Farthing attended Gosport Police Station during October 1998, and was told by the police that the matter would be looked into. Mr Farthing indicated that he had not heard from the police at that time. The Panel has seen no police documents relating to Mr Stewart-Farthing's complaint in October 1998 nor has the Panel seen any document that indicates that any investigation into the death of Mr Cunningham took place at that time.

Second police investigation

5.56 The second police investigation was undertaken between August 1999 and April 2001 and it was conducted in the following phases:

- Phase One was conducted by Detective Chief Inspector (Det Ch Insp) Raymond Burt between August 1999 and April 2000. Det Ch Insp Burt was appointed as Senior Investigating Officer (SIO) to remedy the failings in the first police investigation, which had been identified in the police complaint investigation conducted by Det Supt Longman.
- Phase Two was also conducted by Det Ch Insp Burt between April 2000 and November 2000. Phase Two was established with the investigation elevated to the status of a Force Major Enquiry with an increase in resources being allocated to the investigation. The police investigation was given the title of Operation Rochester.
- Phase Three was conducted by Detective Superintendent (Det Supt) Jonathon (John) James between May 2001 and April 2002. It was established with a proposal to widen the investigation to include additional cases and with the purpose of investigating an unidentified number of patient deaths.

Second police investigation: Phase One

5.57 Following the outcome of the investigation into Det Con Maddison and Det Insp Morgan's conduct during the first police investigation, in August 1999 Det Ch Insp Burt assumed responsibility for addressing any investigative shortcomings that had been identified and pursuing any other appropriate lines of enquiry in the investigation into the death of Mrs Richards. The documents indicate that Det Ch Insp Burt was the only allocated investigating officer during that time (HCO000635, pp8–15).

5.58 Writing to Mr Millett on 10 August, Det Ch Insp Burt advised him of the continuing investigation and sought his guidance in obtaining Mrs Richards' hospital notes. He said:

> "… I am not familiar with the conventions and practices governing the compilation of such notes but I imagine that details of observations made and treatment given together with the rationale for taking such action would be recorded. I understand the underlying sensitivity associated with the release of this documentation and I would welcome your advice on who to approach and what steps I must take to properly seek and obtain the information which I require …" (DOH604060, pp1–2)

5.59 The Trust received Det Ch Insp Burt's letter but there is no record of a response from Mr Millett at that time. Nor is there any evidence that Det Ch Insp Burt considered treating Mr Millett as a potential person of interest in the investigation or considered using police powers to seize the records rather than seeking them on a voluntary basis.

5.60 On 18 August, Det Ch Insp Burt made an entry in a Police Policy File recording the fact that he had taken over the investigation to address the previous inadequacies (HCO000635, p8). The documents show that Det Ch Insp Burt did not record in his Policy File: (i) an investigation strategy, including any witness and suspect strategies, staffing, forensic and budget considerations; (ii) who the actual or potential suspects were; (iii) the resources available to him and which case papers he had received.

5.61 On 29 September, Det Ch Insp Burt met with Det Supt Longman to discuss the investigation report and the lines of enquiry (HCO000635, pp17–18). There are no documents to show which lines of enquiry were discussed.

5.62 On 7 October, Det Ch Insp Burt recorded in the Policy File that he had written to Superintendent David Lockwood, Detective Superintendent (Det Supt) Steven Watts and Detective Chief Superintendent (Det Ch Supt) Keith Akerman in order to inform them of his role and intentions (HCO000635, pp18–19).

5.63 On 8 October, Det Ch Insp Burt recorded that he had written to Mr Millett *"advising him of the continuing investigation and seeking his guidance as regards the acquisition of Mrs Richards hospital notes"* (HCO000635, p20).

5.64 On 19 October, Det Ch Insp Burt requested Mrs Richards' medical records from Haslar Hospital and met with Lesley Humphrey (HCO000732, p2). On 1 November, he wrote thanking Lesley Humphrey for providing copies of Mrs Richards' medical records. He asked for a copy of the X-rays and reiterated Lesley Humphrey's agreement to verify that the records she had provided represented a complete set of Mrs Richards' records. Det Ch Insp Burt added:

> "I also note that you agreed to supply me with copies of any pages from the original file upon which no entries have been made. You pointed out that some of these may currently be missing from the copy file … In order to fully meet the requirements of the Criminal Procedure and Investigations Act 1996 would you please ensure that any material or other information relating to Mrs Richards, which is in the possession of the Portsmouth Health Care NHS Trust, is retained, in its original state, pending the outcome of my investigation. I appreciate that this is something which you have already agreed to do, thank you. I hope that I was able to adequately explain my role in this matter and I assure you that if it becomes necessary to interview any member of the Trust's staff I will seek to undertake the task, by way of yourself, in a way which clearly recognises the sensitivities of this matter. I look forward to meeting you, as arranged, on Thursday the 4th November 1999 at 1230 hours in your office." (HCO000749, pp2–3)

This meant that it had taken Hampshire Constabulary over 12 months from when the first allegation was made to secure the medical records, which was contrary to the established policing principle to secure best evidence.

5.65 On 17 November, Det Ch Insp Burt interviewed Mrs Mackenzie, three months after the start of the second investigation and over 13 months since her complaint to the police was first made (HCO002547). It took a further four months to obtain a written witness statement from Mrs Mackenzie. This was also contrary to the established policing principle to secure best evidence.

5.66 On 11 October, Det Ch Insp Burt contacted the National Crime Faculty (NCF) and was provided with a list of expert names, which included Professor Brian Livesley, consultant

physician at Chelsea and Westminster Hospital (HCO502533, p3; HCO000711, p20). In 1998, the role of the NCF was to provide investigative support to major crime investigations, including assistance in identifying and using independent experts. This was an appropriate way for the police to identify and engage an expert. The decision was made to engage Professor Livesley (HCO000635, p35). On 22 November 1999, Det Ch Insp Burt wrote to Professor Livesley with a detailed summary of Mrs Richards' case (HCO003516). He asked about Professor Livesley's suitability and availability to assist the investigation and whether he would be able to provide an opinion on whether there was evidence to support criminal proceedings against any party to the care of Mrs Richards (p7). The Panel notes that the request from the police was expressed in terms that went beyond matters relating to Mrs Richards' condition, the appropriateness of care and treatment, the standard of care and treatment and the cause of death.

5.67 A month later, on 21 December, Det Ch Insp Burt met Professor Livesley (HCO003503). Professor Livesley provided his draft report to Hampshire Constabulary on or about 12 May 2000 (HCO000997). It included a provisional view on the use of diamorphine by way of syringe driver. The draft report covered its use in general, the dosage in these circumstances and the lack of monitoring (which amounted to a breach of a duty of care). Professor Livesley's view was that Mrs Richards' death was directly attributable to the administration of the large doses of drugs that she continuously received by syringe driver between 18 and 21 August 1998; that no event occurred to break the chain of causation; and that there was no evidence that her death was caused by pneumonia. He concluded:

> "It is most probable if not certain that the cause of Mrs Richards' death was respiratory depression as a consequence of the large doses of drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998 and or the effects of dehydration." (HCO002384, p19)

5.68 Professor Livesley also confirmed that he would support allegations of assault and *"the unlawful killing of Mrs Richards by gross negligence"* against nursing staff and Dr Barton, and suggested that the police undertake other enquiries to determine if other patients at the hospital had been similarly affected (HCO002384, p20).

5.69 The records show that between January and March 2000, the following steps were undertaken, among others:

- On 27 January, Lesley Humphrey provided a statement to Hampshire Constabulary (HCO500214).
- On 8 February, Det Ch Insp Burt wrote to Lesley Humphrey. In this letter, he asked a series of questions about: (i) the transportation of Mrs Richards between Haslar Hospital and Gosport War Memorial Hospital; (ii) on call and consultant cover and referral policies; (iii) the use of syringe drivers including dosage levels, training and supervision; and (iv) whether any other complaints had been made about the clinical management of patients (HCO001010, pp2–5).
- On 25 February, Anne Funnell, Medical Records Manager at Haslar Hospital, provided a statement and medical records (HCO002212).
- On 31 January, Mrs Lack provided a statement (HCO110868) and Mrs Mackenzie did so on 6 March (FAM002551).
- An email on 9 March from Fiona Cameron, General Manager at the Fareham and Gosport Primary Care Trust, to Lesley Humphrey refers to a site visit by Professor Livesley, which is said to have passed off without incident (NHE000809).

5.70 The records indicate that, although a draft response was prepared (DOH103159), the Trust *"never formally replied"* to Det Ch Insp Burt's letter of 8 February *"as situation changed gear"* (DOH604066, p1). The draft response was circulated to Mr Hooper, Barbara Robinson, Fiona Cameron and Lorna Green (Business Manager), who were in turn asked to put it to Dr Lord, Dr Barton, Nurse Beed and the Trust solicitors Beachcroft Wansbroughs for *"sense check"* (NHE000784, p1). On 2 April, in response, Dr Barton provided comments on matters relating to the questions about on call and consultant cover and referral policies and other complaints (NHE000784, pp4–5). Later that month, on 28 April, Dr Barton wrote tendering her resignation (NHE000212, p1).

5.71 On 12 April, Det Ch Insp Burt met with Det Ch Supt Akerman, Det Supt Watts, Superintendent (Supt) Giles Stogden and Detective Inspector (Det Insp) Shand. The briefing note for the meeting says:

> "The purpose of convening this meeting is to seek the authority of the Head of CID to re-designate Operation 'ROCHESTER' as a Force Major Enquiry. It is recommended that this authority be granted on the basis that an exploratory investigation, conducted by DCI BURT, has revealed that there are substantial grounds for suspecting that Gladys Mable RICHARDS, aged 91 years, was unlawfully killed, by staff who were responsible for her care, at the Gosport War Memorial Hospital between the 16th August 1998 and the 22nd August 1998." (HCO003464, p3)

5.72 Additionally, the briefing note records Professor Livesley as saying that he is *"being led inexorably to the conclusion that I will be supporting an allegation of manslaughter in this case and supporting other allegations including assault and actual bodily harm"* (HCO003464, p12). *"This case will pivot on the evidence of Professor LIVESLEY. He is a nationally, and internationally, recognised authority in his field and his expertise and experience comes at commensurate cost"* (HCO003464, p15).

5.73 The same briefing note includes a recommendation *"that consideration be given to establishing an account for this enquiry on the Holmes database. This will provide for the possibility of further suspect cases being discovered when the investigation gathers pace"* (HCO003464, p16).

5.74 In a reference to the possibility of corporate liability, the briefing note suggests:

> "Consideration should be given to discussing this with the Media Departments of the Portsmouth (NHS) Trust and the Royal Hospital Haslar. With regard to the former there is, of course, a possible future issue of corporate liability. Advice of DCS [Detective Chief Superintendent] and Media Services Manager to be sought." (HCO003464, p16)

5.75 The meeting on 12 April 2000 represented the end of Phase One of the second investigation which had taken six months to complete.

Second police investigation: Phase Two

5.76 The briefing note concluding Phase One looked forward to the next phase of the investigation in these terms:

> "Having achieved the aim of Phase One DCI BURT believes that there is now an imperative, with justification, to proceed to Stage Two which will require the declaration of Major Crime Enquiry status to Operation 'ROCHESTER' and the allocation of appropriate resources.

ACTION - DCI BURT to seek authority of DCS to initiate a Major Crime Enquiry." (HCO003464, p12)

5.77 The briefing note lists the proposed Phase Two investigative steps:

"• Complete the investigation into the death of Gladys Mable RICHARDS.

- Research and investigate other cases which may involve a similar pattern of medical conduct at the Gosport War Memorial Hospital.
- Research and investigate the process of certifying deaths arising at the Gosport War Memorial Hospital and the procedures for authorising cremations.
- Research the background of the medical and nursing staff featuring in the case.
- Draw on expertise of Professor LIVESLEY when directing enquiry.
- Draw on expertise of SIO with experience in this form of enquiry." (HCO003464, p13)

5.78 Det Ch Insp Burt proposed that the core personnel should include himself, Det Insp Shand, Detective Sergeant (Det Sgt) David Sackman, Detective Constable (Det Con) Philip Jupe, and an administrative officer. He identified other personnel who would be needed for the investigation, which included four detective constables and a detective superintendent, an enquiry team and a family liaison officer (HCO003464, pp13–14).

5.79 Given the widening scope of the investigation, the documents show concern over finding the necessary resources. The Panel notes that in an email on 13 April 2000 Det Ch Insp Burt told Supt Stogden:

"Apologies for involving you in the meeting yesterday. I must confess I was rather dismayed and surprised at the way it unfolded. We have got to sort out the issue of resourcing major crime – one way or the other. The current unseemly scramble is ridiculous, unprofessional and unsafe. It cannot be right that the burden arising from structural weaknesses in the organisation and the consequent tensions associated with them, rest on the shoulders of one man …" (HCO501820)

5.80 The documents do not show any consideration within Hampshire Constabulary of steps they might have taken to address any ongoing risk to patients at the hospital. The police did not take action to identify the other cases that might have been involved and they continued with a paper-based investigation rather than switching to a computer-based HOLMES account as proposed in the briefing note (HCO003464, p16). The papers do not show any consideration of establishing a Gold Group, through which the investigation could be effectively managed and coordinated.

5.81 Det Ch Insp Burt was to maintain the existing family liaison role with Mrs Richards' daughters (HCO003464, p17). Separate family liaison officers were not appointed, despite the need having been identified in the briefing note (HCO003464, p14). Det Ch Insp Burt's proposed number of hours of overtime and expert funding were approved (HCO001562, p2).

5.82 On 15 May, Det Ch Insp Burt informed Lesley Humphrey that the profile of the investigation was being raised (SOH100041, p68). A week later, Lesley Humphrey wrote to Mr Millett, Tony Horne (Chief Executive of East Hampshire Primary Care Trust), Mr Hooper, Fiona Cameron,

Lorna Green, Dr Richard Ian Reid (Medical Director, Portsmouth HealthCare NHS Trust), Peter King (Personnel Director) and Yvonne Mills (PA to Chairman and Chief Executive at Trust Central Office) to inform them of the development:

> "From 22 May additional officers will be joining the team and the investigation will move into a higher gear in gathering information - formal interviews will be held with potential witnesses [staff who had direct contact with Mrs Richards + staff who can explain policies/procedures etc]. Where appropriate, people like Jane Barton will be afforded some protection with regard to these interviews; presumably to help them avoid incriminating themselves. I will still act as the main contact for the police, in arranging staff interviews; but will need support from Yvonne. I told Ray we would be advising staff to be accompanied when interviewed - MDU/Union/Solicitor etc …" (NHE000831, p1)

She also asked that Dr Lord, Dr Barton and the staff should be informed, and confirmed that the police would liaise with the Trust to prepare a press release.

5.83 The first progress review was held on 16 May 2000 (HCO000635, pp71–86). On 22 May, Det Ch Supt Akerman approved the allocation of four detective constables but approval for a detective sergeant was not granted (HCO002201, p12).

5.84 On 9 June, Det Ch Insp Burt recorded the decision that *"all those persons who may have had a duty of care towards Mrs Richards from her transfer from the RHH [Royal Hospital Haslar] (17/8) until her death at the GWMH (21/8) will be interviewed under caution"* (HCO000635, p87). There are no records showing why the interviews were to be restricted only to those involved in those five days. The interview plan consisted of a basic list of topics without any strategic aims.

5.85 Interviews were conducted between June and December 2000 with Dr Lord, Dr Barton, some nurses, the pharmacist and the ambulance crew. There is little evidence of interview planning following the first progress review of 16 May (HCO000635, pp97–8). There is no evidence of any further interview strategy having been considered or adopted at the subsequent progress reviews (HCO000635, pp92–5, pp100–103).

5.86 Det Ch Insp Burt contacted the GMC and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) as the relevant regulatory bodies on 27 July and again on 18 September 2000 and informed them of the ongoing investigation (HCO000958). The papers do not explain why this step was not taken sooner or why, in the case of the UKCC, only one of the nurses was mentioned (Nurse Beed) (HCO003416).

5.87 On 1 September, Det Ch Insp Burt updated Lesley Humphrey (SOH100041, p69), who, in turn, wrote to Fiona Cameron, Mr Hooper, Mr Millett and Dr Reid, confirming that she had spoken to Det Ch Insp Burt. She wrote that he:

> "… stressed that [the police] did not think there was any 'individual' with criminal intent. What they are exploring is whether institutional practices might constitute a breach of criminal law. He said this is not the only case in the country being explored in this way. Some cases have been taken out of the hands of the local CPS and passed on to London. It is thought, either by Professor Livesey, or by the CPS that there might be a basis for proceeding with a criminal case, they may want to consider if we had any other cases where death occurred in similar circumstances. We would obviously want to co-operate, but I suggest that Lorna checks out the situation with Wansboroughs,

> with regard to confidentiality etc. Sorry, but my gut feeling is that if there is the slightest whiff of a case, that this will go the distance as a test case …" (DOH604070, p1)

5.88 The Panel has seen no documents to explain why, on 1 September 2000, Det Ch Insp Burt told the Trust that Hampshire Constabulary did not think there had been individual criminal intent. The investigation was far from concluded and it is not clear why Hampshire Constabulary expressed this view at this early stage.

5.89 On 18 September, Det Ch Insp Burt asked Lesley Humphrey whether Dr Barton or Nurse Beed had been the subject of any complaints or allegations made to the Trust or any other body regarding issues of professional competence or standards of patient care (HCO000940).

5.90 The Trust sought advice from Beachcroft Wansbroughs, who replied on 20 September that, following a Court of Appeal decision in February 2000, the Trust could only be culpable for gross negligence manslaughter where the guilt of an individual had been established. Given that the police had now indicated that they did not consider any individual had committed a criminal offence, it was unclear as to what the police had in mind. The advice continued:

> "I cannot see any reason why the Trust should be expected to provide the police with details of other similar cases (if indeed there have been any similar cases) in circumstances where no complaint has been made. Such a request would, as you rightly point out in your letter, raise issues of confidentiality. I consider that it would benefit all concerned if the police/CPS concluded this investigation and closed their files now …" (NHE000778, p2)

5.91 On 5 October, Beachcroft Wansbroughs added:

> "If neither Dr Barton or Mr Beed have ever been the subject of any complaints then I see no harm in advising Mr Burt that this is the position. However, if either of them have been the subject of any previous complaints I do not consider that the Trust should provide Mr Burt with that information. Mrs Lack and Mrs Mackenzie made serious allegations to the police relating to their late mother's care. The Trust and its staff have co-operated with the police with their enquiries. I can see no justification for providing the police with information about any entirely unrelated matters which have not been a subject of any complaint to police. Mr Burt now appears to be on a fishing expedition and as I indicated in my letter of 20 September 2000 it is not clear to me why the police inquiry is going in this direction. If the Trust provided any such information it would raise not only issues of patient confidentiality but also Mr Beed would no doubt take the view that the Trust had breached mutual respect and confidentiality as between employer and employee." (NHE000775, p1)

5.92 By this stage (October 2000), at least four complaints had been made to the Trust (SOH900117, SOH900121, SOH900119, SOH900123).

5.93 Seven months after Det Ch Insp Burt's end of Phase One briefing, which reported that Professor Livesley's opinion was supportive of an allegation of manslaughter, Professor Livesley completed his first report (CPS001688). In doing so, he made it clear that his report, dated 9 November 2000, was provided for discussion only and that he required a conference with the CPS and Counsel before finalising his report. He expressed serious concern about what appeared to be *"a culture of inappropriate clinical practice"* (p1). Professor Livesley said that he could find no evidence for Mrs Richards requiring the subcutaneous drugs that Dr Barton prescribed when Mrs Richards was first admitted to Daedalus Ward for rehabilitation. Similarly,

as far as Mrs Richards' readmission to Daedalus Ward was concerned, he could find no evidence to suggest that Mrs Richards had a condition requiring the continuous subcutaneous administration of diamorphine, midazolam, haloperidol and hyoscine, and the lack of appropriate fluid and food intake until she died. Professor Livesley summed up the position in these terms:

> "It appears probable, therefore, that this has been an institutionalised practice that may have led to the premature and unlawful death of other elderly people admitted to Daedalus ward at Gosport War Memorial Hospital. I recommend that further enquiries be made to determine if other patients at the Gosport War Memorial Hospital have been affected in a manner similar to that of Mrs RICHARDS and particularly those who have been under the care of Dr BARTON." (CPS001688, p1)

5.94 In his report, Professor Livesley concluded:

> "Doctor Jane Barton prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys Richards in a manner as to cause her death … Mr. Philip James Beed, Ms. Margaret Couchman and Ms. Christine Joice were also knowingly responsible for the administration of these drugs … As a result of being given these drugs, Mrs. Richards was unlawfully killed." (CPS001688, p2)

5.95 On 10 November, Det Ch Insp Burt wrote to Mr Millett requesting the retention of all records in all wards and departments in relation to Mrs Richards (HCO003647) and wrote again on 20 November clarifying the request (HCO000891, p2).

5.96 On 11 November, Det Ch Insp Burt recorded in his Policy File that *"The 'Phase 2' investigation is complete"* (HCO000635, p104). A month later he referred the case to David Connor, at the CPS in Portsmouth, stating:

> "Professor LIVESLEY is profoundly concerned by the circumstances of this case and it will be seen that he is quite clear in his opinion that Mrs RICHARDS was unlawfully killed. In addition to Dr BARTON he believes that certain members of the nursing staff, namely Philip BEED, Margaret COUCHMAN and Christine JOICE, may also be criminally culpable. Professor LIVESLEY has indicated that, in the event of proceedings being considered, it would be of considerable benefit if he could be afforded the opportunity of meeting a CPS representative or Counsel, familiar with the issues arising from this case, in order to discuss the detailed presentation of his evidence. In any event the Senior Investigating Officer, and the key members of his team, would welcome a conference with the reviewing lawyer at his or her earliest convenience. Such is the level of concern, felt by Professor LIVESLEY, about the facts of this case that he has recommended that further enquiries be carried out to determine if other patients at the War Memorial Hospital have been affected in a manner similar to that of Mrs RICHARDS." (HCO003640, p3)

5.97 Despite Professor Livesley's concerns about other patients, Hampshire Constabulary decided not to widen the investigation at this stage but rather decided to await the CPS decision in the case of Mrs Richards. This meant that the police did not take any steps to investigate any other cases at that time. This decision had the potential to undermine Hampshire Constabulary's ability to secure best evidence and also overlooked any potential ongoing risk to patient safety (HCO000635, p106).

5.98 Det Ch Insp Burt sought the advice of the CPS regarding:

> "… the criminal culpability of Dr BARTON and other persons whose actions are specifically commented upon by Professor LIVESLEY in his report. The Senior Investigating Officer would also welcome an opportunity to discuss any issues of corporate liability and the potential implications stemming from a further phase to this investigation which would be likely to evoke a substantial amount of local and national public and media interest." (CPS001568, p4)

The police investigation was to be put on hold pending the CPS's advice. There is no evidence of the police taking any action to pursue Professor Livesley's recommendation in respect of other patients at the hospital or to consider issues of corporate liability.

5.99 The documents suggest that Hampshire Constabulary met with Mr Connor on 4 January 2001 (HCO000635, p115), but no record of what was discussed is available. There is also no record of how the CPS involvement was moved from the CPS locally to its national headquarters in Ludgate Hill in London, where Paul Close, a CPS lawyer, assumed responsibility. Some months earlier, Lesley Humphrey had noted that Hampshire Constabulary had said that *"this is not the only case in the country being explored in this way. Some cases have been taken out of the hands of the local CPS and passed on to London"* (DOH604070, p1).

5.100 The documents suggest that Mr Close updated the police. On 1 March, Det Ch Insp Burt replied seeking a *"pre-opinion conference"* with the CPS and with David Perry QC, a barrister whose advice had been sought by the CPS (CPS001886, pp2–3). Det Ch Insp Burt added:

> "I am certain that both you and Mr PERRY would find it helpful to meet Professor LIVESLEY and the discuss the case with him … if it is felt the Professor's opinions require validating then perhaps consideration should be given by the CPS to engaging a person who is suitably medically qualified to review the opinions tendered which appear to be remarkably clear and unequivocal. It is clear that Professor LIVESLEY is likely to be strongly challenged in court and this is a further reason for an early, informed, assessment to be made of his potential as a witness by those responsible for deciding upon and conducting any future proceeding. Clearly the facts and issues surrounding this case are sensitive and topical. I think I would be failing in my responsibility, therefore, if I did not draw your attention to concerns, openly expressed to me on more than one occasion by persons directly involved in this case, that the decision to prosecute, or not, might be subject to 'political' influence given the perceived plight of the National Health Service and the forthcoming General Election. (You will have seen Professor LIVESLEY's recommendation so far as the option to search for other, potential, cases is concerned.)" (CPS001886, pp2–3)

The documents do not show what Det Ch Insp Burt had in mind when suggesting that this case might be subject to *"political influence"* but he concluded his letter by confirming his intent to dispel such concerns.

5.101 On 16 March, Mr Close sent formal written instructions to Mr Perry, and asked for advice on whether there was evidence to charge Dr Barton, Nurse Beed, Staff Nurse Margaret Couchman or Nurse Christine Joice with the unlawful killing of Mrs Richards (CPS001882).

5.102 At the end of March, Det Ch Insp Burt wrote to Mr Close again, informing him that Mrs Mackenzie had been in contact with the *Portsmouth News*. Det Ch Insp Burt stressed his frustration at the press interest as he had *"gone to great pains to avoid any sort of disclosure*

to the media" (CPS001882, p4). The Policy File records that *"an updated media release was prepared … in consultation with PHCT [Portsmouth HealthCare NHS Trust] and RHH"* (HCO000635, p123).

5.103 On 3 April, the police investigation was reported in the *Portsmouth News*. The article stated: *"One Source told The News the deaths of as many as 600 elderly people could be re-examined. It is thought the use of the pain-killing drug diamorphine might form a part of any future inquiry"* (HCO000849, p2). There are no documents available to the Panel to show whether or not the police were the *"Source"* or the basis for the reference to 600 deaths.

5.104 On the same day, Det Sgt Sackman reported that Pauline Spilka, a nursing auxiliary on Daedalus Ward, had been in touch following the newspaper article. She had been *"off sick with stress during our investigation last summer and you may recall refused to make herself available for interview"* (HCO003576, p1). Det Sgt Sackman stated:

> "She describes the ward at the 'Dead Loss' ward as opposed to Daedlus. She describes the regime of [the nurse] as being geared towards euthanasia. Although not specifically recalling the Gladys Richards case (she is aware of it) she recalls coming into conflict with [the nurse] over the death of an elderly cancer patient who was put onto a syringe driver and subsequently died. The patient was always making demands and was considered a nuisance. In her estimation he was some way from death when the driver was introduced. He quickly lapsed into unconsciousness and died after 4-5 days. She also recalls an elderly lady brought onto the ward very ill and immediately put onto a driver. Her family insisted that she be allowed to die naturally without a syringe driver being used. Following the withdrawal she recovered sufficiently to be discharged home to her daughter …
>
> The can has been opened!!!!!" (HCO003576)

5.105 Det Sgt Sackman said that Pauline Spilka was prepared to make a detailed statement (HCO000905, pp3–11) highlighting her concerns. In her statement Pauline Spilka said that the:

> "Indiscriminate use of Syringe Drivers on Patients in the Daedalus Ward at Gosport War Memorial Hospital is my main concern. It appeared to me then and more so now that euthanasia was practised by the nursing staff. I cannot offer an explanation as to why I did not challenge what I saw at that time." (HCO000905, p4)

Pauline Spilka described how, on the arrival of each patient, the doctor would write up a prescription for the use of a syringe driver. This would allow nurses to use it without further reference to a doctor and that there had been abnormally high mortality rates on the ward. Pauline Spilka also went into detail about the two patients referred to in Det Sgt Sackman's email above.

5.106 On 14 April, Pauline Spilka's statement was sent to the CPS by Det Ch Insp Burt, who also confirmed that five other people had come forward to express concern over the treatment and death of family members at the hospital. The letter stated:

> "Our current policy is to await the outcome of the decision concerning Mrs Richards deceased before considering our position regarding the scrutiny of other cases. I'm sure you will appreciate that this development, and the problem caused by the unwelcome media disclosure, is placing us under considerable pressure." (HCO000905, p2)

5.107 There are no documents available to the Panel to explain the reference to *"considerable pressure"*. Nor are there any documents to suggest that the CPS considered the statement made by Pauline Spilka.

5.108 On 17 April, Det Ch Supt Akerman wrote to the CPS (HCO003143) and expressed the view that he had been *"disturbed by the unequivocal nature"* of Professor Livesley's evidence. He also asked for priority attention to be given to the case, in light of its significance and the possible widening of the investigation. Det Ch Insp Burt spoke with and then wrote to Lesley Humphrey regarding the further complaints that had been received by Hampshire Constabulary. The patients' family members had been informed that a police officer would be in contact in due course to establish the details of their concerns. He would not seek disclosure of the records relating to other patients because he was satisfied with Mr Millett's assurances (regarding the securing of records) in his letter of 27 November 2000 (HCO000896). Lesley Humphrey confirmed that she did not seek disclosure of the other patient names as she wished to maintain the integrity of the Trust's position. The letter concluded with acknowledgement that Det Ch Insp Burt and Lesley Humphrey had agreed to continue to work closely together in the interests of resolving this issue in a fair and timely way and with the interests of all parties in mind (HCO000864).

5.109 On 2 May 2001, the police held a confidential briefing with the GMC, which indicated that the recent publicity, and the fact that other people had recently come forward, had prompted them to reconsider the position over the possible suspension of Dr Barton (HCO000635, p138). The GMC made a formal request for disclosure (HCO005424). Similarly, the UKCC contacted the police about Nurse Beed and disclosure (HCO005424, p3). A meeting was held with the UKCC and a letter requesting disclosure was later received (HCO000635, p143).

5.110 On 12 May, Det Ch Insp Burt circulated a management briefing note suggesting that:

> "… recent events justify a change in the current policy of awaiting the outcome of the CPS's deliberations over the Gladys Richards' allegation before deciding the way forward in terms of a widening of the investigation … It was always recognised, however, that Professor Livesley's comments would require careful reflection whatever the outcome. However, recent developments following the unexpected publicity have significantly altered the position: Nine persons have come forward expressing 'concerns' over relatives that have died at the GWMH and a former nurse (whistle blower) has made a statement which points to the possible existence of a 'culture of euthanasia' and the role played by the ward manager Philip Beed … I believe that Phase 3 of Operation 'Rochester' should be commenced as soon as possible on the basis that the situation has changed significantly thereby raising the level of risk substantially. We should not await the outcome of the CPS's decision before doing this. The statement recently provided by the nurse has been passed to the CPS lawyer who is also aware of the other persons who have expressed concern … I understand that, given the change of circumstances, there is now a need to act positively and quickly. The potential of the case has always been recognised. There is also, however, a need to act with care given the highly sensitive nature of this case. The new SIO must be fully briefed, asap, and enabled to freely make policy that will take the enquiry forward – I believe I could usefully contribute to this process." (HCO000635, pp140–1)

5.111 The documents available to the Panel do not clearly indicate why Det Ch Insp Burt could no longer perform the role of SIO.

5.112 In response to a request for information about other cases elsewhere, where Professor Livesley had provided expert evidence, Det Sgt Sackman identified a case of attempted murder which had been successfully prosecuted in 1998–99. He had spoken with the case officer, who confirmed that Professor Livesley had been similarly unequivocal in his view of that case but, in other cases where he was not convinced that a criminal act had taken place, he had said so. The case officer also confirmed that Professor Livesley's evidence had been presented to the jury in layman's terms and that he had withstood cross examination from the defence. Det Sgt Sackman concluded that the case officer was *"obviously impressed"* (HCO000873).

5.113 On 15 May, Det Ch Insp Burt telephoned Mr Close and asked that a conference that was due to be held on 23 May be postponed while the investigation was reviewed, as a result of further persons coming forward following the recent publicity (HCO003541).

Second police investigation: Phase Three

5.114 On 21 May 2001, a strategy meeting was held to facilitate a handover of responsibility from Det Ch Insp Burt to Det Supt James (HCO000635, pp155–8). The handover briefing note said:

> "A hand-over is a critical event in any investigation but it is now an appropriate time to undertake a change of SIO. It was originally agreed that this investigation would be placed 'on hold' and that the hand-over process would take place once the CPS had decided in the Richards' case. However, given the changed circumstances arising from the recent media disclosure, there is a immediate need to progress both the hand-over and the enquiry without delay." (HCO000635, p156)

5.115 In his handover briefing note, Det Ch Insp Burt also said that the *"use of HOLMES may be considered appropriate"* (HCO000635, p157). Det Supt James had recently returned to policing having taken a 12-month break (HCO502478, pp1–3). It is not clear to the Panel what steps he had taken to keep himself abreast of policing developments and investigation strategy or on what basis Hampshire Constabulary decided that Det Supt James was the most suitable person to take over this investigation.

5.116 The handover briefing note also set out a list of matters that would need to be considered as part of Phase Three, including: wider support mechanisms for families affected; corporate liability issues; GMC; Her Majesty's Coroner; Professor Livesley; good practice with reference to the 'Shipman' case (HCO000635, pp157–8).

5.117 The Panel has not seen any documents to confirm that any of these tasks took place at the point of handover.

5.118 On 31 May, Mr Perry advised, in writing, that having considered the case of Gladys Richards the *"evidence does not reveal the commission of any offence"*. This advice consisted of a summary of: the case background, Professor Livesley's report, the accounts from Dr Barton, Dr Lord, a number of nurses, the hospital pharmacist, Mrs Lack and Mrs Mackenzie, together with a summary of the law on gross negligence manslaughter and murder (CPS001872, p2). His advice appears to contain no rationale for this decision.

5.119 Det Supt James met with Professor Livesley on 31 May and wrote to him on 5 June, setting out the matters that they had discussed (HCO000906, pp2–5).

5.120 The first issue was *"identifying the deaths we would want to examine in greater detail from the total deaths over an agreed period"* (HCO000906, p2). The letter set out the strategy that had been discussed for approaching this issue. In particular:

- The population of deaths to be examined would be: *"All those deaths in a period from twelve months before the commencement of the employment of Dr. Barton or Mr. Beed, dependent upon who was first appointed, through to the date of the notification to the Health Authority of the second investigation into the death of Gladys Richards"* (HCO000906, p2).
- It was noted that the period of *"twelve months before"* would allow some scrutiny to identify *"Whether the clinical practices you identify preceded the arrival of Dr. Barton and Mr. Beed*" (HCO000906, p2).
- *"Whether there is a need to widen the scale of the investigation, depending upon the outcome above. A control sample for comparative purposes if the examination of the pre-Beed/Barton regime reveals no irregularities in patient care practice"* (HCO000906, p3).
- It was also noted that the cut-off date was *"appropriate at this stage, given that the commencement of Ray Burt's investigation precipitated a series of actions within the Health Trust and the hospital"* (HCO000906, p3).

5.121 The second issue was *"the process for examining the deaths on a case-by-case basis to identify: Those that may be categorised as unlawful. The criminal liability of any individual"* (HCO000906, p3). A detailed proposed strategy was set out in the letter.

5.122 Professor Livesley responded and suggested that the police obtain the assistance of the statisticians who had been engaged in the Shipman case. He also set out the basic principles of gross negligence manslaughter by reference to an extract from a 2000 publication entitled *Law for Doctors*. Professor Livesley confirmed that in his assessment of the Gladys Richards case it met the legal criteria for gross negligence manslaughter and that he would apply the same principles to any other cases. He also suggested amending the 'high risk, low risk criteria' to a set of criteria that were more clearly associated with the patient's condition, which included *"obviously stable"*, *"obviously terminal"* and *"obviously unexpected"* with explanations as to what each meant. He pointed out that in cases where patients had been classed as terminal there would still need to be comment on *"whether their terminal management had been appropriate"* (HCO000871, pp3–4).

5.123 The documents suggest that Hampshire Constabulary met with the CPS on 14 June (HCO000869).

5.124 Following the meeting, Det Supt James recorded:

> "Make arrangements to identify and consult with a practising Geriatric Consultant at a hospital outside Portsmouth Health Authority area to determine: i)Whether or not Professor Livesley's observations concerning pre-prescription to patients on admission are reflected in practise. ii)Whether or not Professor Livesley's observations concerning continuous administration via syringe driver (as Richards) without review are reflected in practise." (HCO000636, p19)

His reasoning for this was: *"Issues raised are central to Livesley's conclusion. Senior counsel requests that practicing consultant's interim view is sought to assist decision making process"* (HCO000636, p19).

5.125 On 18 June, Det Supt James recorded the decision to brief Dr Keith Mundy, consultant geriatrician, on Mrs Richards' case for a view on the circumstances (HCO000636, p21).

5.126 On 19 June, and in preparation for the meeting that would take place later that day with Professor Livesley, Det Sgt Sackman faxed two briefing notes and a copy of Professor Livesley's letter of 18 June to Mr Close and requested that the documents be forwarded to Mr Perry (CPS001894).

5.127 The first briefing note set out a summary of two other cases in which Professor Livesley had been involved. One case related to deaths in a nursing home. The allegations related to residents who had been subjected to a regime of excessive fluids leading to heart failure and death. The note reported that seven deaths had resulted in gross negligence manslaughter charges and proceedings against staff. The other case involved deaths in an intensive care unit at Basildon Hospital. The deaths were alleged to be the result of doctors prescribing larger than appropriate quantities of morphine-based drugs to patients whose medical support had been withdrawn, thereby shortening the lives of terminally ill patients. This case was still under investigation. Professor Livesley's report in this case was said to be unambiguous and unequivocal, as were the reports of a toxicologist and intensive care unit specialist (CPS001894, p2).

5.128 The second briefing note confirmed that Hampshire Constabulary had consulted with Dr Mundy, a practising consultant geriatrician who was based at a hospital in Surrey (HCO000869, p2). The briefing note explained that Dr Mundy had been briefed on the general chronology of events preceding Mrs Richards' death and that he had, in turn, expressed concerns about this case. The Panel has seen no documents to show that the views of Dr Mundy were acted upon in relation to the Gladys Richards investigation. In particular, Dr Mundy was not asked to provide a full written report nor has the Panel seen any document to confirm that the CPS or Mr Perry took Dr Mundy's views into consideration (CPS001894, p3).

5.129 Professor Livesley attended a conference on 19 June with Mr Perry, Det Supt James and Mr Close, and subsequently described the two-hour meeting in the following terms: *"I was verbally abused, bullied, and attacked by Mr Perry so much so that I complained loudly that this was not professional"* (BLI000035, p1).

5.130 The documents examined by the Panel raise important issues about the treatment of Professor Livesley as an expert witness, exemplified by the conference on 19 June, and these are considered later in this chapter and in the Conclusions to this Report in Chapter 12.

5.131 On the same day, Professor Livesley wrote to Det Supt James withdrawing his letter of 18 June 2001 and the letter and report of 9 November 2000, which he pointed out had been initially provided for discussion only (HCO002251).

5.132 On 2 July, Mr Perry provided updated advice:

> "After reading the papers with some care, my preliminary analysis was that the accounts given by Doctor Barton and others involved in the care of Mrs. Richards supported the following findings of fact:
>
> (i) that on 11th August 1998 Mrs. Richards was very frail
>
> (ii) by 17th August 1998 Mrs. Richards' condition had deteriorated and she was in pain

> (iii) that the decision to administer drugs by way of a syringe driver was a decision made by Doctor Barton on clinical grounds and this decision was supported by the evidence of Philip Beed and Doctor Lord;
>
> (iv) that the drugs administered to Mrs. Richards were used routinely in palliative care." (CPS001399, pp36–7)

5.133 As noted by Mr Perry in his advice: *"These findings were of course subject to the views contained in Professor Livesley's report dated 1st November 2000"* (CPS001399, p37).

5.134 The Panel notes that in his advice and in relation to Mrs Richards' condition on 11 August 1998, Mr Perry also observed that Dr Barton asserted in her police statement (dated 25 July 2000) that *"upon admission on the 11 August 1998 Doctor Barton was of the opinion that because of her dementia, her hip fracture and her recent major surgery, Mrs Richards was close to death. She scored 2 on the Bartel"* (CPS001399, p12).

5.135 In her police interview statement, Dr Barton stated:

> "In my view Mrs Richards was probably near to death in terms of weeks and months from her dementia before the hip fracture supervened. Given her transfer from nursing home to acute hospital and then to continuing care and the fact that she had recently undergone major surgery in addition to her frailty and dementia, I appreciated that there was a possibility that she might die sooner rather than later." (CPS001691, p4)

5.136 On 11 August 1998, Dr Barton had recorded in the medical records that Mrs Richards was a *"frail demented lady not obviously in pain … please make comfortable … I am happy for nursing staff to confirm death"* (CPS001691, pp3–4).

5.137 The Panel has seen no documents to explain why Dr Barton considered Mrs Richards was near to death by weeks or months before she suffered her hip fracture. It is also not clear from Dr Barton's police statement or from the records she made at the time why, on 11 August 1998, she considered that there was a possibility Mrs Richards might die sooner rather than later. The Panel has seen no documents to confirm that Mrs Richards was in any pain on 11 or 12 August and no documents that explain why, therefore, having assessed Mrs Richards as *"not obviously in pain"*, Dr Barton instructed staff to *"make [her] comfortable"* and that she was *"happy for nursing staff to confirm death"* (CPS001691, p4).

5.138 In his advice and in relation to Mrs Richards' condition on 17 August 1998, Mr Perry observed that, in her police statement Dr Barton had stated that, on 17 August, *"Mrs Richards had been on intravenous morphine until shortly before her transfer [back to the hospital] … [which] explains Mrs Richards apparent peacefulness upon transfer"* (CPS001399, p13). In his report, Professor Livesley had observed that the medical records confirmed that: on 14 August, Mrs Richards' dislocated hip had been corrected at the Haslar Hospital *"under sedation using 2mg of midazolam"*; that, after the procedure, she had *"gradually become more responsive"* and that, *"apart from two tablets of co-codamol on the 15th August 1998 she did not need to be given any pain relief following the reduction of her hip dislocation"* (BLC003926, pp7–8). The records confirm that on her arrival at Gosport War Memorial Hospital, Mrs Richards was noted to be in pain and distress and was not peaceful. The records also show that, following her arrival at the hospital, morphine oral solution was administered to Mrs Richards. The records confirm that Haslar Hospital staff had noted on the transfer letter to Gosport War Memorial Hospital *"no follow up unless complications"*.

5.139 In relation to Mrs Richards' condition on 18 August 1998, in her statement to the police, Dr Barton said:

> "… when I examined Mrs Richards there was a lot of swelling and tenderness around the area of the prosthesis. There was no evidence of infection at that time and it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated. This was in all probability the cause of Mrs Richards' significant pain and unfortunately a not uncommon sequel to a further manipulation required to reduce the dislocation. This complication would not have been amenable to any surgical intervention and again further transfer of such a frail and unwell elderly lady was not in her best interest and was inappropriate." (CPS001691, pp7–8)

5.140 The Panel has not seen any document that shows that Dr Barton made any record of any detail relating to a haematoma in the medical records at any point. The Panel has seen no document that confirms that any investigation of the presence or nature of the haematoma was carried out by Dr Barton. The Panel has not seen any document that shows that Dr Barton consulted with the clinicians at the Haslar Hospital about the haematoma and any possible treatment. In her police interview, Dr Lord was asked whether, having read the clinical notes, she could indicate any particular *"thing"* that Mrs Richards was dying of, and she answered *"no"* (CPS001053, p35).

5.141 Mrs Lack stated that, on 18 August 1998, Mrs Richards was still unconscious from the effects of the morphine oral solution and that Nurse Beed explained that a syringe driver was going to be used to ensure that Mrs Richards was pain free at all times. Mrs Lack also stated that Dr Barton had arrived afterwards and confirmed the presence of a haematoma and that the use of a syringe driver was the kindest way to treat Mrs Richards (CPS001688, p27). The medical records confirm that at 11:45 the administration of diamorphine 40 mg, haloperidol 5 mg and midazolam 20 mg was commenced by syringe driver. Thereafter the drugs were administered by syringe driver daily until 21 August 1998, when Mrs Richards died.

5.142 In relation to Professor Livesley, the advice stated:

> "In his summary of the relevant facts Professor Livesley draws attention to the following matters.
>
> (i) On 11th August 1998 Doctor Barton prescribed oramorph [morphine oral solution] and large dose ranges of diamorphine, hyoscine and midazolam. These were to be given subcutaneously and continuously over periods of twenty-four hours for an undetermined number of days.
>
> (ii) On 17th August 1998 there is no evidence that Mrs Richards, although in pain, had any specific life-threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover. Despite this on 18th August 1998, Doctor Barton, who did not seek any other medical opinion, prescribed diamorphine, midazolam, haloperidal and hyoscine to be given subcutaneously and continuously over periods of twenty-four hours.
>
> (iii) Neither midazolam nor haloperidal is licensed for subcutaneous administration.
>
> (iv) When the syringe driver was being used to administer the subcutaneous drugs, there is no evidence that Mrs Richards was given fluids or food in any appropriate manner.

(v) There is no evidence that in fulfilling her duty of care Doctor Barton reviewed appropriately Mrs Richards' condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.

(vi) There is no evidence that in fulfilling their duty of care Mr. Philip Beed, Ms. Margaret Couchman and Ms. Christine Joice reviewed appropriately Mrs Richards' condition to determine if any reduction in the drug treatment they were administering was indicated.

(vii) There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification from 18th August 1998 until Mrs Richards died on 21st August 1998.

(viii) Although Doctor Barton recorded that death was due to bronchopneumonia there is no clinical pathological evidence that this was correct.

(ix) It is beyond reasonable doubt that the death of Mrs Richards was the result of continuous subcutanous administration of diamorphine haloperidol midazolam and hyoscine in the dosages given." (CPS001399, pp10–11)

5.143 Professor Livesley's opinion, as reported by Mr Perry, was that:

"Mrs Richards was unlawfully killed, by the continuous administration of drugs actively prescribed by Doctor Barton. He further concludes that Philip Beed, Margaret Couchman and Christine Joice knowingly and continuously administered diamorphine, haloperidal, midazolam and hyoscine to Mrs Richards when they should have recognised the fatal consequences of so doing." (CPS001399, pp10–11)

5.144 In relation to the conference with Professor Livesley on 19 June 2001, Mr Perry's advice stated:

"In the course of the conference the following matters emerged:

(i) although Professor Livesley had concluded in his initial medical report that Mrs Richards had been unlawfully killed, he was not entirely clear of the legal ingredients of gross negligence manslaughter;

(ii) that Doctor Barton's decisions were entitled to be afforded some respect because she was involved in Mrs. Richards' care as the 'front line' clinician

(iii) Doctor Barton's decisions could find support among a responsible body of medical opinion

(iv) bronchopneumonia as cause of death could not be contradicted

(v) it is not possible, in the absence of any post-mortem finding, to exclude a heart attack as a possible cause of death." (CPS001399, pp37–8)

5.145 The five issues listed above led Mr Perry to conclude that Professor Livesley's position was untenable and that he could not be relied upon as an expert witness in this case.

5.146 In the later police conduct investigation, Hampshire Constabulary observed that *"it is not known precisely why the meeting with Treasury Counsel [appears to have been] so catastrophic in its outcome. No documentation of the precise nature and detail of the discussion has been*

found", despite the statement of Det Supt James (HCO502145, p6). Following this finding, Det Supt James provided a witness statement in which he detailed the discussion that had taken place during the meeting with Counsel. He recollected that, during the meeting, Professor Livesley conceded that he was unable to substantiate several of the medical conclusions in his report (HCO501911). The lack of any formal record of the meeting was not surprising. According to Deputy Chief Constable (Dep Ch Const) Ian Readhead, who was asked about the position in September 2003 during a PCA investigation, there appeared to have been a rule that no notes of such a meeting were to be taken (HCO005270, pp12–13).

5.147 The Panel notes that Mr Perry was instructed to consider whether there was any evidence to charge Dr Barton, Nurse Beed, Staff Nurse Couchman and Nurse Joice with the unlawful killing of Mrs Richards (CPS001882). In the event, the issue of potential culpability was not examined on a person-by-person basis.

5.148 The advice confirmed that the offences to be considered by Mr Perry were gross negligence manslaughter and murder (CPS001399, p2). However, it is clear from the documentation seen by the Panel that the police had considered the possibility of corporate liability as early as 15 October 1998 (CPS001657). This issue appeared on a number of occasions, in correspondence and in the Policy File (HCO000635, p61). The question of corporate liability had been raised by Det Ch Insp Burt as a matter requiring advice in his letter to the CPS (HCO501545, p3). This letter was sent to Mr Perry for consideration in April 2001 (CPS001886).

5.149 The documents provide no explanation as to why consideration of corporate offences did not feature as part of Mr Perry's instructions from the CPS (CPS001882).

5.150 Mr Perry refers to a thorough investigation having been carried out by Hampshire Constabulary (CPS001399, p1).

5.151 The documents show that the following matters were not addressed in Mr Perry's advice. He raised no concerns about the inadequacies of Det Con Maddison's investigation as noted by Det Supt Longman in his investigation report dated 16 August 1999 (HCO000635, pp14–15). There was no reference to Dr Mundy's provisional views, which expressed concern about the case, despite this second opinion being obtained at Mr Perry's request. The advice contained no reference to the evidence of the nursing auxiliary Pauline Spilka, which may or may not have been provided to Mr Perry.

5.152 On 10 July, Professor Livesley produced an amended report (BLC003926). Contrary to the account given by Det Supt James of the conference with Mr Perry, Professor Livesley remained committed to his earlier views and simply removed the reference to Mrs Richards being 'unlawfully killed'.

5.153 The Panel has seen no evidence that Professor Livesley's amended report was provided to or considered by the CPS or given to Mr Perry for consideration. Notwithstanding the outcome of the conference between Professor Livesley and Mr Perry, Hampshire Constabulary continued to use Professor Livesley's November 2000 report, by circulating it to the regulatory bodies. Professor Livesley would subsequently complain about the handling of his report (BLI000021, p1; BLI000018).

5.154 By this stage allegations had been made to Hampshire Constabulary regarding the deaths of nine patients (HCO000635, p140) and Det Sgt Sackman was asked to identify those that were similar to the case of Mrs Richards. He selected the cases that he assessed as having

the following features: *"non life threatening condition on admission, syringe driver used to administer drugs, death within a short period of admission unexpectedly"* (HCO000636, p28, decision 21). He selected Eva Page, Arthur Cunningham, Robert Wilson and Alice Wilkie (HCO000636, p28). The Panel has seen no documents explaining why the other five cases were not further investigated at this stage. It is not clear to the Panel why Hampshire Constabulary did not instruct Professor Livesley to comment on all nine cases.

5.155 On 6 July, Det Supt James wrote to Lesley Humphrey requesting the records in these cases and said:

> "It would be my aim to complete the analysis as soon as possible and then determine whether or not any circumstances give cause for further investigation once the advice is received. I hope you will appreciate that we are not pre-judging the situation but simply endeavouring to maximise the information available to us to decide clearly and rationally whether or not the police investigation should proceed further." (HCO005653, p2)

5.156 On 20 July, Det Supt James noted:

> "Meeting arranged with CHI [Commission for Health Improvement] Assistant Director operations and investigations manager for today's date. Brief on all relevant issues concerning GWMH including concerns Prof Livesley and others and potential type of deaths where there may be concerns, i.e. in region of 600." (HCO000636, p35)

5.157 His reasoning was recorded as:

> "Important to share all relevant information to ensure CHI can make informed decisions about continuing investigation in accordance with their terms of reference. Important they are encouraged to become involved given (??)(=current / uncertain) nature of future police investigations." (HCO000636, p35)

5.158 The police note of 20 July is the first reference to the figure of 600 potential deaths. The note does not explain how this figure was calculated or by whom.

5.159 On the same day, Mr Close met with Mr Wheeler, the local CPS branch prosecutor, and Hampshire Constabulary. During this meeting, the police indicated that they would be looking at other cases (CPS000985, p4).

5.160 On 7 August, Mr Close wrote to the police about Mrs Richards' death. He referred to a phone call with Det Ch Insp Clarke four days earlier and the meeting with the police at the CPS Headquarters on 20 July 2001. Mr Close added that *"the police requested that the CPS took no action pending confirmation from the police as to what steps it proposed to take with regard to the other associated complainants"* (HCO501896, p1). He continued:

> "I confirm that having considered this matter, I am not satisfied that there is sufficient evidence to provide a realistic prospect of a conviction, against anyone, in respect of any criminal offence alleged in the papers. I have, therefore, advised that criminal proceedings should not be instituted." (HCO501896, p1)

5.161 Mr Close went on to provide a list of evidential observations to assist the police. This marked the end of the case in relation to Mrs Richards (HCO501896).

5.162 Despite the additional investigations and expert reports that were obtained by Hampshire Constabulary, this appears to be the very last time that the CPS reviewed or considered the death of Mrs Richards with a view to prosecution.

5.163 On 18 October 2001, Dr Mundy produced a report on Mr Cunningham, Mrs Wilkie, Mr Wilson and Mrs Page (CPS001565). On 12 December, Professor Gary Ford, a medical professor at Newcastle University, produced a report on Mrs Richards, Mr Cunningham, Mrs Wilkie, Mr Wilson and Mrs Page (CPS001563).

5.164 Both experts raised concerns about inappropriate and excessive prescribing contributing to and hastening death. Professor Ford raised serious concerns about general management of older people and recommended that further enquiries and police interviews should be carried out.

5.165 The Policy File shows that, between 20 July and 31 October 2001, the main steps taken by the police related to the provision of information to the Commission for Health Improvement (CHI). Aside from engaging Professor Ford and Dr Mundy to comment on four cases only, no other investigation steps were taken and no investigation strategy was formulated during this period (HCO000636).

The end of the second investigation

5.166 Despite the concerns that had been raised by Professor Livesley, Dr Mundy and Professor Ford, on 28 January 2002 Det Supt James took the decision to end the police investigation, which he recorded as follows: *"SIO's decision re wider police investigation into deaths at Gosport War Memorial Hospital is that further investigation would not be appropriate"* (HCO000636, p49). The reasons given for reaching this decision were the lapse of time since Det Con Maddison's initial report from 5 October 1998, the lack of evidence of any unlawfulness having occurred, conflict between experts, the lack of certainty of any particular outcome and the fact that other agencies (such as the GMC) had a role. Finally, Det Supt James stated that *"To proceed on basis of current information would necessitate investigating up to 600 deaths. A considerable number raising massive public concerns with no certainty of outcomes in respect of criminal investigations"* (p49).

5.167 The Panel has seen no documents providing details of meetings, briefings or other considerations leading to the decision to close the second investigation. No closure report has been disclosed. Moreover, the documents indicate that the decision to end the investigation was not discussed with the CPS.

5.168 After the decision to end the investigation, Det Supt James took steps to inform the Portsmouth HealthCare NHS Trust, the Portsmouth and South East Hampshire Health Authority, the Director of Public Health, the UKCC, the GMC, the Medical Defence Union and the families of the outcome and to provide copies of the expert reports (HCO000636, p51). This was effectively a handover to those organisations. His last entry was on 15 April 2002 regarding the Medical Defence Union's objection to the disclosure of expert reports to the families whose relatives had been the subject of those reports (p55).

Events that prompted a new investigation

5.169 The documents show that there were a series of events which obliged Hampshire Constabulary to reverse their decision and to institute a further investigation.

5.170 Between January 2002 and June 2002, eight family members made complaints to Hampshire Constabulary regarding the police conduct of the second police investigation (CPS001015, p1; HCO502054). These complaints variously highlighted concerns about the second police investigation and the lack of communication from the police.

5.171 The Panel notes that, in her letter of complaint, Mrs Mackenzie expressed concern that the second police investigation was incomplete. In particular, she highlighted that 14 people who had previously been in contact with the police regarding deaths at the hospital had not yet been interviewed. She also raised a concern that the CPS was unaware of the additional four cases that had been selected by the police for further investigation and expert opinion in 2001. Mrs Mackenzie further highlighted that the other deaths known to the police had not been investigated at all, one of which had occurred as recently as September 2001 (CPS000991).

5.172 Mrs Mackenzie further pointed out that there were additional deaths at the hospital which Det Supt James had not taken into consideration. She suggested that the police did not want to pursue the cases in order to avoid the embarrassment of previous investigative inadequacies. Mrs Mackenzie sent her letter to Paul Kernaghan, Chief Constable, and copied it to David Blunkett as Home Secretary, Nigel Waterson MP and Peter Viggers MP, the PCA, Mr Close and Mr Perry (CPS000991).

5.173 On 17 April 2002, Ch Supt Basson instructed Chief Superintendent (Ch Supt) Daniel Clacher to gather information in relation to Det Supt James' investigation (HCO501969). On 9 May, Ch Supt Clacher reported back (HCO501918). Four days later Ch Supt Clacher was instructed to oversee an investigation into all other complaints relating to Det Supt James and to the second police investigation (CPS001015, p1).

5.174 In May 2002, the CHI concluded its investigation and published its report in July 2002 (CPS001567). The Panel notes that the CHI investigation terms of reference were to look at *"whether, since 1998 there had been a failure of trust systems to ensure good quality patient care"* (CPS001567, p15), and that the key conclusions of the CHI report identified *"a failure of trust systems to ensure good quality patient care"* (CPS001567, p9).

5.175 On 21 July, Ch Supt Clacher submitted a further report to Assistant Chief Constable (Asst Ch Const) Phillip Jacobs and Dep Ch Const Readhead. It recognised that, although each complainant had specific grievances, he had identified a number of common points in the complaints including that *"The enquiry into the death of their elderly relatives was not conducted diligently or professionally and failed to take into account all of the evidence available."* Ch Supt Clacher concluded that there was a case to answer (HCO501909, p24).

5.176 On 23 July, Dep Ch Const Readhead wrote to Roger Daw at Portsmouth CPS. He set out the background and outcome to the investigation into Mrs Richards' death. He also explained that, although the police had decided to investigate four other similar cases, those cases had not been passed to the CPS for consideration because *"they were all of a similar nature to the Richards' case and would therefore attract similar comment from your office [the CPS]"* (HCO502056, p2).

5.177 Dep Ch Const Readhead confirmed that, following receipt of Ch Supt Clacher's report, he had taken the view that the other four cases should have been submitted to the CPS and that he had now instructed Detective Superintendent (Det Supt) Paul Stickler to collate this additional evidence and pass it to the CPS (HCO502056).

5.178 The Panel notes that Dep Ch Const Readhead also informed Mr Daw that Det Supt James had given senior police officers and regulatory bodies the impression that the four cases had been referred to the CPS when in fact they had not (HCO502056).

5.179 On 19 August, Dep Ch Const Readhead wrote to numerous family members confirming receipt of Ch Supt Clacher's report. He informed them that Det Supt Stickler would be asked to submit Ch Supt Clacher's report, the outstanding evidence and the CHI report to the CPS for consideration. He emphasised that this would not be a new investigation, and that no additional evidence would be sought by the police at this time (for example, see CPS000913).

5.180 A number of family members responded to Dep Ch Const Readhead expressing their concern about the content of his letter, the inadequacy of the investigation and highlighting the conclusions in the CHI report as evidence that supported their complaints and concerns (for example, see CPS000914).

5.181 Between July and September 2002, numerous family members approached Hampshire Constabulary, the CPS, the Director of Public Prosecutions and the Attorney General (for example, see CPS000925). The letters raised concerns about patient care at the hospital and the inadequacies of the police investigations. Some of the letters were also copied to Tony Blair as Prime Minister, Mr Blunkett as Home Secretary, Alan Milburn as Secretary of State for Health and Iain Duncan Smith as Leader of the Opposition.

5.182 One of the letters was from Paule Ripley, who explained that, although her husband, James Ripley, had survived his stay at the hospital in April 2000, she wished for the circumstances surrounding his care to be investigated. The nature of her concern was that, having been admitted to the hospital for rest and care to treat a serious flare-up of arthritis, her husband became unconscious on 9 May 2000. He was said to have suffered a stroke and was transferred to Haslar Hospital where, in fact, it was discovered that he had not suffered a stroke. Rather, he had suffered an analgesic overdose and was so severely dehydrated that he had been hallucinating. Mrs Ripley's husband never returned to Gosport War Memorial Hospital after that and instead received his rehabilitation care at home. At the time of writing her letter, Mrs Ripley's husband was alive. Mrs Ripley stated that she was aware of other cases that were similar to her husband's (CPS000910).

5.183 On 4 September 2002, the Attorney General's office requested that a briefing note and draft response to the letters be provided (CPS000909).

5.184 The Attorney General responded to the families, and Mr Close was also instructed to provide responses to the families (for example, see CPS000897, CPS000985).

5.185 On 12 September, Det Supt Stickler provided a report for submission to the CPS, in which he stated:

> "I would point out that no consideration appears to have been given as to the hospital's liability under health and safety legislation. These enquiries are normally left to the Health and Safety Executive to investigate but equally they can be conducted by the police … The allegations being made by the families are effectively that the hospital was guilty of institutionalised euthanasia. Establishing any intent to kill would be onerous, if indeed that was the position, but if it can be established that the practices at the hospital were in themselves flawed, negligent or otherwise so dangerous that patients under their care were likely to be exposed to risks, then health and safety legislation may be an appropriate investigative approach." (HCO501965, p2)

5.186 On 16 September, Det Supt Stickler sent Ch Supt Clacher's report, Professor Ford's report, Dr Mundy's report, the clinical notes relating to Mr Cunningham, Mrs Wilkie, Mr Wilson and Mrs Page, and the CHI report to Mr Close. In his covering letter, Det Supt Stickler stated:

> "Whilst it is accepted that statements would need to be obtained and probably further questions asked, the report does highlight some key findings and I would appreciate a view as to whether a prima facie case may already be established under Section 3. To conduct such a health and safety investigation would clearly be time consuming and expensive which may not be justified if the CPS were able to offer some advice at this stage as to the viability or otherwise of a prosecution." (HCO500266, pp1–2)

5.187 On 17 September 2002, Det Supt Stickler telephoned Mr Close to discuss the further papers he had collated. In his telephone note, Mr Close recorded:

> "It was not clear what papers had been collated - it seems quite clear though that no real further investigation has been carried out or any relevant evidence obtained - there are seemingly 2 lever arch folders - the second of which can basically be ignored as it contains some miscellaneous medical records - the bulk of the papers may comprise the CHI report." (CPS000933, p1)

He stated that Det Supt Stickler *"seemed very concerned that there was a very urgent and early review of the papers and advice given about possible proceedings including possible offences under section 3 of Health and Safety at Work Act"* (CPS000933, p1).

5.188 As Chapter 4 has explained, Sir Liam Donaldson, the Chief Medical Officer, commissioned Professor Richard Baker to conduct a statistical analysis of mortality rates at the hospital, including an audit of use of opioids. In addition, Dep Ch Const Readhead emailed Assistant Chief Constable (Asst Ch Const) Colin Smith, Asst Ch Const Jacobs, Chief Superintendent (Ch Supt) Derek Stevens (PSD), Det Ch Supt Clacher and Det Supt Stickler, indicating that as a result of the recent developments it was imperative to appoint a new SIO with immediate effect. He recorded:

> "Since we spoke yesterday other developments have occurred which in my professional judgment make it imperative that we appoint a new SIO with immediate effect to progress the submission through the CPS and to commence joint work with Professor Baker from the CMO office. I will brief you am on 13.9.02." (HCO502354, p1)

5.189 On 16 September, a meeting was held at the hospital. As Chapter 4 explains, the purpose of the meeting was to make staff aware of the audit by Professor Baker but the folder of documents recording nurses' concerns in 1991/92 ('the nurses' dossier') was also handed over. Following an internal meeting at the hospital, Mr Cruddace telephoned Dep Ch Const Readhead on 18 September to notify him that he had a bundle of documents relating to the nurses' concerns raised in 1991 (HCO502424).

5.190 A file note by Dep Ch Const Readhead dated 19 September 2002 recorded that he and Det Ch Supt Watts (he had been promoted in the meantime) *"Agreed to raise this to a critical incident and to form a Gold Control group"* (HCO502455, p1).

5.191 On 19 September, a meeting was held between senior NHS staff and police at Hampshire Constabulary Headquarters. Attendees included Dep Ch Const Readhead, Det Ch Supt Watts, Dr Simon Tanner, Director of Public Health for Hampshire and Isle of Wight Strategic Health

Authority (SHA) and Gareth Cruddace, Chief Executive of Hampshire and Isle of Wight SHA (HCO501582).

5.192 As a result of this meeting, it was decided that another police investigation was required. An enquiry team would be assembled to: (i) examine the new documentation and investigate the events of 1991; (ii) review existing evidence and new material to identify any additional viable lines of enquiry; (iii) submit the new material to the experts and CPS; and (iv) examine individual and corporate liability. Additionally, there would be a press release and a freephone number publicised (CPS000379, pp3–4).

5.193 On 19 September, Det Ch Supt Watts contacted Mr Close by telephone. The note of the conversation records that Det Ch Supt Watts introduced himself as the SIO and informed Mr Close that:

> "… there had been a major development. The Police do not know how but papers had been sent to the PHC [Portsmouth HealthCare NHS] Trust setting out details of various nurses concerns in 1991 regarding medical personnel, the administration of drugs and seemingly deaths at the hospital. The Trust have apparently appointed 2 senior officials to investigate. Police are to make enquiries to find out the provenance of these papers and why, seemingly, they were not brought to the attention of the police during the original enquiry. Copies of these papers and a police report will follow as soon as possible. The Police believe that these papers must be considered in detail in light of the other recent papers which they have collated." (CPS000932, p1)

5.194 Despite the events outlined above, no entries appeared in the police Policy File between 16 April 2002 and 10 September 2002 (HCO000636, HCO000637).

The third police investigation

5.195 Between 2002 and 2006, the third investigation was undertaken.

5.196 The principal investigative steps undertaken between 2002 and 2006 were as follows:

- an investigation into the 1991 nurses' concerns
- the collation of medical records and the instruction of a team of five medical experts (the Key Clinical Team) and a solicitor experienced in medical legal issues, to undertake a screening of 91 patient deaths
- the instruction of experts, who provided reports on some or all of the cases identified during the Key Clinical Team screening process and the case of Mrs Richards
- the collation of witness statements including statements from hospital staff and family members
- the interview under caution of various hospital staff, including senior executives, nurses and doctors
- the collation of other documents such as hospital protocols and Dr Barton's job description
- the statements, interviews, documents and expert reports outlined above and in relation to those cases were sent to the CPS for review and a decision on prosecution.

5.197 The decisions on whether to prosecute were reached by the CPS in December 2006 and the families, relevant organisations and the public were informed.

5.198 The documents confirm that, during the third investigation, new complaints and concerns relating to patient care and deaths at the hospital were reported to the police, who considered the deaths of 91 patients.

5.199 From 20 September, the SHA operated a telephone helpline, which enabled people to call in with concerns and questions. On 2 October 2002, the line was closed following discussions between Dep Ch Const Readhead and Alan Pickering, the then Acting Chief Executive of Fareham and Gosport Primary Care Trust.

5.200 By the time the line was closed, 36 callers had made contact and had left their details. The line was subsequently replaced with an answerphone service (HCO501587).

5.201 Detective Inspector (Det Insp) Nigel Niven telephoned Mr Close on 18 December to explain that the SHA had proposed to undertake its own investigation, and CHI had proposed to undertake a second investigation. Det Insp Niven explained that he was concerned about a potential conflict of interest, prejudice and contamination arising in circumstances where the SHA and CHI were carrying out enquiries and investigations at the same time as Hampshire Constabulary and that there was *"potential impact on any corporate liability"* (CPS001007, p1).

5.202 Mr Close's note of the conversation records that the *"Hospital personnel involved appear to be anticipating potential culpability and possibility of being subject of police enquiry. Police want to discuss general issues and in particular those arising from points of reference in the other investigations"* (CPS001007, p1).

5.203 Mr Close's record of advice includes this reference:

> "It may be they were on notice about real problems as a result of the 'secret' report prepared in 1990. The legal position in the issues arising is somewhat nebulous and probably unique. I suggested in passing that the police should concentrate on their primary investigation and not be deflected by side issues arising from the NHS Trust and the CHI. As both were seemingly intent on pursuing their own investigations and not holding back at all until the police investigation had been completed the police should simply press on regardless and not be deflected." (CPS001007, p1)

5.204 The documents do not explicitly confirm that the reference to the *"secret report"* was intended to relate to the nurses' dossier but this seems to be what was intended.

5.205 On 6 January 2003, Mr Close wrote to the police advising that the second investigation by CHI, or the SHA-commissioned management investigation (described in Chapter 4), would not itself cause any prejudice to the police enquiry but he highlighted a number of difficulties that may arise from the investigations (CPS001001, p1).

5.206 Due to the lack of clarity in Mr Close's advice, the police sought further advice from Michael Forster, a barrister. Mr Forster advised, on 4 February, that the investigations were likely to prejudice the police investigation and the interests of justice, and that the police investigation should be conducted expeditiously so that the SHA and CHI enquiries could be conducted as soon as reasonably practical (HCO000637, p75).

5.207 Meanwhile, the records indicate that on 13 January 2003 Hampshire Constabulary held a meeting with Sir Liam Donaldson to discuss the issue of prejudice (HCO000637, p84).

5.208 Between October 2002 and August 2003, Hampshire Constabulary investigated the nurses' dossier, taking statements from those who had been named in the 1991 documents

(HCO502362, HCO110800, HCO110869, HCO110813, HCO110842, HCO110899, HCO110911, HCO110777, HCO004127, HCO111005, HCO110993, HCO004128, HCO111017, HCO006709, HCO111107, HCO111239, HCO111226, HCO111145, HCO111144, HCO111146, HCO111147, HCO004143, HCO006363, HCO004056, HCO004134, HCO004136, HCO004060, HCO110593, HCO004126, HCO004127, HCO004134).

5.209 The police also conducted interviews under caution with Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust, and Mr Horne, Chief Executive of East Hampshire Primary Care Trust (HCO109812, HCO109813, HCO109814). Statements were taken from a number of individuals holding managerial positions within the hospital, but not from Mr Hooper, Mr Millett, Dr Bob Logan (a consultant geriatrician) and Dr Barton. The police interviewed nursing staff but did not ask them to provide examples and details of patient cases that had caused concern. The nursing staff confirmed that the system was that Dr Barton would prescribe the use of the syringe driver and medication and a senior nurse would decide when to use a syringe driver and administer the drugs (HCO110869).

5.210 On 11 September 2003, the police held a Family Group meeting where the 1991 nurses' concerns were raised. Det Ch Supt Watts provided a PowerPoint presentation to the families (HCO000638, p93; HCO005295). The presentation included:

> "A considerable amount of work was then done to trace all the relevant staff connected with these documents and conduct such enquiries as was necessary to satisfy ourselves that no offences had taken place. This task was completed by the beginning of this year. We were content that no offences had been committed in respect of these documents. The NHS then allowed the two reassigned Managers to return to their former roles." (HCO005295, p4)

5.211 The Panel has not seen any document to confirm on what basis the police determined that no offences had been committed in respect of the 1991 events. The Panel notes that the investigation into the 1991 events was incomplete in that the police had not sought to establish the specific details of the nurses' concerns, the chain of command on the wards and the hospital, and the persons responsible for implementing the use of syringe drivers and diamorphine. The police also did not enquire into staff training and senior-level knowledge and involvement in the response to the nurses' concerns. In addition, Hampshire Constabulary did not enquire into the result of the SHA-commissioned management investigation. Following the decision that no offences had been committed in respect of the 1991 documents, the police did not invite the SHA or CHI to reinstate their investigation.

5.212 Following their consideration of the 1991 documents, the police engaged experts in the following two stages:

- Stage one: The Key Clinical Team was a team of five medical experts in varying disciplines, led by Professor Robert Forrest, Professor of Forensic Toxicology at the University of Sheffield, whose role was to provide a preliminary assessment referred to as a 'screening' of all 91 cases. The Key Clinical Team's conclusions were then reviewed by Matthew Lohn, a solicitor who was experienced in GMC proceedings. (As described in Chapter 6, Mr Lohn was also engaged by the GMC to advise on its investigations. The potential conflict of interest was highlighted in September 2003, and Mr Lohn subsequently withdrew the provision of his services to the GMC.) The purpose of the screening exercise was to assess and allocate cases into categories: Category A (natural deaths), Category B (unclear deaths) or Category C (deaths unexplained by illness which *"meant that the treatment had killed the patient and there was no*

explanation for that treatment") and Category 1 (optimal care), Category 2 (suboptimal care), Category 3 (negligent care) or Category 4 (where the care was intended to cause harm) (HCO000638, p48). The process of assessment adopted by the Key Clinical Team is set out in the Key Clinical Team Table on the Gosport Independent Panel website (https://gosportpanel.independent.gov.uk/expert). The documents viewed by the Panel show that the Key Clinical Team members independently assessed each case and reached their own views on categorisation. The documents also show that their views were not unified; however, the Key Clinical Team later reached a collective and final view on each case. It is not clear from the documents by what criteria each category was assessed, or on what basis the Key Clinical Team reached its final and collective view. After the Key Clinical Team's final categorisation, Mr Lohn performed a review of the cases and advised Hampshire Constabulary on the next stage of the investigation.

- Stage two: It was decided that 14 Category 3 cases would be the subject of a criminal investigation. The case of Mrs Richards, although not deemed to be a Category 3 case, was also the subject of further expert assessment and opinion, making 15 cases in total. It is not clear from the documents why those 15 cases were chosen and others were not. As part of the further investigation, Hampshire Constabulary commissioned a number of experts to carry out a full analysis of and provide an opinion on the standard of treatment and care, and the cause of death in those cases. Hampshire Constabulary engaged two principal experts: Professor David Black, consultant geriatrician, and Dr Andrew Wilcock, lecturer and reader in palliative care and medical oncology at Nottingham University; and in some cases other experts were asked to provide assessment and opinion on discrete medical issues pertaining to that patient.

5.213 Between 2004 and 2006, the following patient deaths were the subject of further expert assessment and reports:

1. Edwin Carter
2. Arthur Cunningham
3. Elsie Devine
4. Sheila Gregory
5. Clifford Houghton
6. Thomas Jarman
7. Ruby Lake
8. Elsie Lavender
9. Geoffrey Packman
10. Leslie Pittock
11. Gladys Richards
12. Helena Service
13. Enid Spurgin
14. Robert Wilson
15. Norma Windsor

5.214 A detailed summary of the expert involvement in the police investigations can be found in the Expert Overview on the Gosport Independent Panel website (https://gosportpanel.independent.gov.uk/expert).

5.215 As outlined in paragraph 5.209, during this period, in addition to engaging the experts, Hampshire Constabulary also carried out other investigative steps such as taking witness statements and conducting interviews under caution.

5.216 On 28 September 2005, the police met with Mr Perry and the CPS in conference to discuss the cases that had been reviewed thus far (HCO000041). The police investigation continued.

5.217 On 7 June 2006, the police updated the CPS (HCO000643, pp142–3). In early August, the police met again with Mr Perry and the CPS. The note of the meeting recorded Mr Perry's views on five of the investigation files as follows:

> "Preliminary advice 5 cases … Insufficient evidence to support manslaughter … To paraphrase … Devine … Problem re the issue of terminal phase … Doubtful levels of drugs negligent … Pittock … Doubtful terminal decline … Cannot prove life shortened … Doubtful gross negligence … Lavender … Black … drugs shortened in minor fashion … reached terminal phase … complex challenging geriatric circumstances … Cunningham … Dr BLACK raised causation problem … divergance of opinion over whether drugs excessive … Lake … Disagreement over appropriate treatment … No causation/gross negligence … Spurgin/Wilson and Packman remain under review." (HCO000643, p188)

5.218 On 14 September 2006, the police provided the final submission of additional papers and representations to the CPS (HCO000643, pp200–3). The submission highlighted the strengths in the expert evidence in the cases of Enid Spurgin, Geoffrey Packman and Elsie Lavender, and stressed that the experts had said that these patients were suffering from reversible conditions and that it was unlikely that they had entered a *"natural irreversible terminal decline"* (HCO000643, p202).

5.219 The Panel has undertaken a MADS (Messages Actions Documents Statements) review of the third investigation. (A MADS review is simply a review of all the documents generated by an investigation that are logged on the HOLMES police computer system.) This review shows that the third investigation consisted of, among other things, taking witness statements, obtaining medical records, instructing experts and conducting interviews under caution with suspects. The MADS review showed that the investigation was a process of collation but not exploration or analysis of the evidence that had been gathered.

5.220 As acknowledged by Dep Ch Const Readhead, when an allegation was made to Hampshire Constabulary then it was necessary for the police to comply with the National Crime Reporting Standards (NCRS) (HCO501872). The Panel has not seen any documents to confirm that any of the allegations relating to the hospital were recorded in accordance with the NCRS.

5.221 On 27 October 2006, Mr Perry provided a written advice on each of the following cases: Elsie Devine (DPR100008), Leslie Pittock (DPR100009), Elsie Lavender (DPR100010), Ruby Lake (DPR100011), Arthur Cunningham (DPR100012), Enid Spurgin (DPR100013), Robert Wilson (DPR100014), Geoffrey Packman (DPR100002), Helena Service (DPR100003) and Sheila Gregory (DPR100004), together with a general note on the investigation (DPR100007).

5.222 In each case, Mr Perry determined that the evidence did not indicate the commission of the offence of gross negligence manslaughter. In doing so, he considered the essential

questions below with reliance upon the opinions and conclusions of the medical experts, as well as other evidence. The essential questions were as follows:

1. Could a reasonable clinician have concluded that the patient had naturally entered the terminal phase?
2. Had the patient in fact entered the terminal phase?
3. Was an adequate assessment of the patient's condition and needs carried out?
4. Was the use of the drugs appropriate in the circumstances?
5. Was the starting dosage and/or escalation of drugs excessive for the patient's needs?
6. Did the drugs contribute more than minimally, negligibly or trivially to the patient's death?

5.223 These questions can be summarised in the following way: (i) did Dr Barton cause the drugs to be administered to the patient in a manner that was a breach of her duty of care (i.e. negligent); (ii) did the administration of those drugs more than minimally cause the patient's death; and (iii) if so, could the breach of duty be characterised as grossly negligent. Answers in the affirmative to each of these questions would have suggested that Dr Barton was guilty of gross negligence manslaughter.

5.224 It is clear from Mr Perry's analysis that the experts' views were seen as presenting an equivocal picture, which meant that the evidence in each case fell below the evidential threshold for a charge of gross negligence manslaughter, as set by the Code for Crown Prosecutors. If a jury could not be sure that Dr Barton had caused drugs to be administered to patients in a manner that was a breach of her duty of care, had more than minimally caused the patient's death by the administration of those drugs, and had breached her duty of care in a way that could be characterised as grossly negligent, then a prosecution should not be commenced.

5.225 The Panel notes the evidential difficulty that arose from the nature of the expert opinions in the ten cases referred to the CPS and Mr Perry. The Panel understands the reasoning for Mr Perry's conclusions in respect of offences of gross negligence manslaughter. The challenging nature of the expert evidence was a recurring issue in the investigation. While the preponderance of advice favoured there being a significant problem at the hospital, there was a lack of unanimity around the precise cause and effect. Professor Livesley had provided unequivocal expert evidence during the second police investigation but his evidence was considered to have been undermined during a conference with Mr Perry, as described earlier in this chapter.

5.226 Mr Perry's advice did not extend to the possibility that offences may have been committed by Dr Barton and others, including the Trust, under health and safety legislation. The Panel has seen no evidence to indicate that full consideration was given to whether such offences had been committed.

5.227 The Panel has seen no documents that confirm that a copy of Mr Perry's advice was provided to the police nor to explain the refusal to do so. The documents indicate that Mr Close provided a CPS determination to Hampshire Constabulary, which was based on the advice he had received from Mr Perry. This marked the end of the third investigation.

5.228 After the conclusion of the third investigation, Hampshire Constabulary provided evidence collated during the investigation to the Portsmouth Coroner, the GMC and the Nursing and Midwifery Council. In 2009, the Coroner held ten inquests into the deaths of the ten patients,

as described in Chapter 8, and the GMC held Fitness to Practise proceedings in relation to Dr Barton as described in Chapter 6.

5.229 Following the conclusion of the ten inquests and the GMC proceedings in 2009, the families sought a review of the decisions on prosecution. The police provided the transcripts of those proceedings to the CPS which in turn instructed Mr Perry to review this evidence and the decisions on prosecution.

5.230 In his further advice of 31 March 2010, Mr Perry concluded that his overall view on prosecution had not altered. He also observed that *"in the case of each … the essential balance of the expert evidence remains the same".* He also observed:

> "… where the opinions of the experts have been revised or amplified the effect has been to underline the difficulty in this case of proving negligence, causation and gross negligence to the criminal standard … the admissions made by Dr Barton during the course of the GMC proceedings provide some additional evidence of supportive of negligence. However, they do not amount to admissions of gross negligence …" (DPR100005, p24)

5.231 Mr Perry also pointed out that the focus of the inquests and the GMC proceedings was different to what would take precedence in a criminal trial, and that the standard of proof in both proceedings was lower than that which applies in a criminal trial.

Corporate liability and health and safety offences

5.232 The Panel notes that, during the course of all three investigations, the need to look into corporate liability and health and safety offences was brought to the attention of senior police personnel and the CPS. Hampshire Constabulary sought legal advice on these issues but the documents suggest that neither the case for corporate prosecutions nor the case for bringing prosecutions under health and safety legislation was fully or properly considered.

5.233 As early as 15 October 1998, the police had identified that the death of a person in a hospital might be the result of corporate and/or systemic failings and, therefore, that the corporate entity and persons in position of responsibility might be culpable for any crime that had been committed (CPS001657).

5.234 Throughout the three police investigations, a variety of evidence was obtained which, in the Panel's view, indicated that offences under the Health and Safety at Work Act 1974, and/or corporate manslaughter, might have been committed. Among other matters, Professor Livesley had raised the possibility that any wrongdoing might be wider than one patient and one doctor. The police had interviewed numerous members of staff at the hospital, including Nurse Beed and Dr Lord, both of whom had confirmed their understanding and knowledge of the diamorphine and syringe driver practices in use at the hospital. The nursing auxiliary Pauline Spilka had provided a statement in which she alleged that a practice of euthanasia existed at the hospital (HCO000905, pp3–11). Professor Ford and Dr Mundy had each raised concerns about the general systems and practices at the hospital. All of which gave rise to lines of enquiry in relation to the question of clinical governance and corporate liability. Thereafter, in July 2002, CHI published its report, which concluded that there had been a failure of Trust systems in the provision of care at the hospital (CPS001567).

5.235 By late November 2002, the police had met with the CPS which provided advice in relation to the cases of Gladys Richards, Arthur Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

5.236 Specifically, Mr Close advised that *"there is no prospect of a prosecution on the papers now in the possession of the CPS"* and *"in the absence of further evidence generated as a result of the additional information presented on 19/9/02, there are no additional avenues to follow in respect of criminal offences, but HSE offences may arise"* (CPS001008, p1). In December 2002, the police met with the management of Hampshire and Isle of Wight SHA, including Dr Tanner and Mr Richard Samuel, Assistant CEO, to discuss the proposed Trust investigation. Det Insp Niven's record of the meeting confirms that he informed the Trust:

> "If it could be evidentially ascertained that Dr Barton or any others had caused deaths then the clear issue of potential corporate liability might arise. That being a possibility then it might be inappropriate for the SHA to conduct their investigation for fear of contamination or prejudice." (HCO000637, p53)

5.237 The police then turned back to the CPS for advice on the issue of corporate liability. Mr Close advised that the investigation should focus on Dr Barton and not the Trust and that any interviews of corporate personnel would likely be irrelevant until a case against Dr Barton had been established. The Panel notes the restrictive interpretation of corporate liability used by Det Insp Niven. To prove corporate manslaughter at that time, the law required there to be an identifiable individual who had committed the offence. However, to prove a health and safety offence, there did not have to be causation, only a risk of injury.

5.238 On 3 October 2003, Sir Liam Donaldson provided Professor Baker's audit report to Hampshire Constabulary. On 6 July 2004, the police met once again with the CPS (HCO000640, p83). The issue of corporate liability was discussed but with no firm conclusion.

5.239 By 13 May 2005, the police wrote to the CPS in these terms:

> "May I now ask that consideration is given to the appointment of Counsel to secure advice in respect of potential 'Consultant' and 'Corporate' culpability and the way forward in this regard. Whilst I appreciate that such issues are not likely to arise in the event that CPS advise that there is not a sufficiency of evidence to prosecute Dr BARTON, it would seem eminently sensible to commission counsel to review the case at this stage." (CPS000421, pp2–3)

5.240 In September 2005, the police met with Mr Perry and the CPS. Mr Perry provided a provisional view on the cases he had reviewed thus far and indicated that they did not meet the threshold for prosecution in relation to the offence of gross negligence manslaughter. The note of the meeting records:

> "The reporting of Professor BAKER and the CHI in addition to the police investigation provided a formidable case for the GMC and possibly a Health and Safety prosecution, although the value of an HSE prosecution would be debatable … Corporate liability was academic at this stage, but in such an event counsel anticipated the usual difficulties proving cause of death and controlling mind, identifying individual(s) taking on the personna of the company. In terms of any Health and Safety prosecution. CPS Mr CLOSE commented that is was not usual policy to prosecute unless there was an accompanying homicide charge." (HCO000041, pp2–3)

5.241 The 2008 Memorandum by the Health and Safety Executive (HSE) highlighted a number of prosecutions of NHS Trusts for health and safety offences occurring between 1998 and 2008.[1] By way of example, in 2004, Southampton NHS Trust was prosecuted for an offence contrary to section 3 of the Health and Safety at Work Act 1974. This followed the successful prosecution of two doctors for gross negligence manslaughter arising out of the same incident. The police and HSE had worked together in what was a joint investigation.

5.242 The document *Work-related Deaths: A protocol for liaison* was published in 1998 and was agreed between the HSE, the Association of Chief Police Officers (ACPO) and the CPS.[2] It sets out the principles for effective liaison between those organisations. It allows for transition of a police investigation into a health and safety investigation (paragraph 1.1), for a police investigation to be assisted by the HSE (paragraph 2.1), or for an HSE investigation to be assisted by the police (paragraph 2.5). Where an investigation into suspicious deaths by the police focuses on murder and/or manslaughter, the HSE can investigate or consider health and safety offences alongside them, particularly if individuals were not criminally culpable, but systems had failed.

5.243 This demonstrates that for offences investigated from 1998 onwards the police and HSE could, if necessary, work together, and that clinical staff and the hospital could be prosecuted for separate types of offences.

5.244 The potential need to liaise with the HSE was variously noted, including within a Hampshire Situation Report dated 29 June 2004, when Detective Sergeant Owen Kenny wrote:

> "Contact has been made with HSE at their Basingstoke office, which covers Gosport. Martin VAN LANKER at that office has been given brief details of Rochester by telephone. Arrangements are in hand for Mr VAN LANKER and/or his manager Bob MELDRUM to attend the incident room for a meeting in the near future." (GMC101104, p111)

The Panel has not seen any records relating to this and it is not clear whether any such meeting ever took place and if so what occurred.

Police and CPS relationship

5.245 As a general observation, the Panel notes that the more complex an investigation, and the greater its scale, the more likely it is that investigative advice and guidance will be required by the police from the CPS. In a case as complex and novel as this one, there may have been an increased need for regular and constructive liaison between the police and the CPS but this does not appear to have been the case.

5.246 By August 2003, Det Insp Niven had decided to engage the services of Mr Lohn *"to assist in investigation and interview strategy as sought by the SIO"* (HCO000638, p85). The CPS was not consulted on this decision at the time and only later became aware of Mr Lohn's involvement, at which time Mr Close expressed concern about Mr Lohn's suitability to advise on a complex criminal investigation. It is not clear from the documents viewed by the Panel how and on what basis Mr Lohn was selected. When the wisdom of this decision was questioned by the CPS, the police responded:

1 Health and Safety Executive, 2008. *Memorandum by the Health and Safety Executive (HSE)*. PS 07. https://publications.parliament.uk/pa/cm200708/cmselect/cmhealth/1137/1137we08.htm (accessed 10 May 2018).

2 *Work-related Deaths: A protocol for liaison (England and Wales)*. www.hse.gov.uk/pubns/wrdp1.pdf (accessed 4 May 2018).

> "For the avoidance of any doubt - In respect of FFW [solicitors' firm where Mr Lohn was a partner] - they are there to assist us investigate. The decision making process has and will always rest with yourselves. We do not seek to substitute the CPS. The results of the experts is in its infancy and should only be viewed as a filtering process as had been explained." (HCO000638, p126)

5.247 On 6 July 2004, Det Ch Supt Watts and Detective Superintendent (Det Supt) David Williams met with the CPS casework directorate at Ludgate Hill. The purpose of the meeting was to provide an investigation overview, discuss timescales and priority cases. It was also agreed that the CPS would *"review the briefing file and provide a briefing note"*. This appears to be the first occasion when the investigation strategy was discussed in any detail.

5.248 On 2 August 2005, Det Supt Williams noted in a letter to the CPS:

> "I am informed that Mr CLOSE is in possession of Counsels advice which was due to be completed by the end of June. My staff have made requests on my behalf to meet with Counsel to discuss issues arising from their review of the papers submitted to date, but no such meeting has been forthcoming. I will make myself available between Tuesday 9th August and Thursday 18th August to discuss the case, please make every attempt to facilitate a meeting within these timescales with Counsel. Finally I understand that Mr CLOSE has refused a request for advanced sight of Counsels advice prior to any meeting commenting that it is not CPS policy to release this material. Given the complex nature of the investigation and the continued investment of police staff and experts to investigate at significant cost to the public purse this position seems to me to be totally unwarranted. The advice would serve to give an advanced current legal perspective of the investigation to date and would factor heavily into the ongoing investigative strategy. May I ask that you reconsider the position in terms of disclosure of Counsels advice, if it is against existing policy please forward a copy of that policy and register that I wish to formally appeal the position." (HCO000642, p113)

The Panel is not aware of any protocol that explains this approach, which did not seem to assist the police in their investigation.

5.249 Eventually, on 15 December 2006, the CPS confirmed the decisions not to prosecute. By that time, Mr Close had already informed Ann Reeves, the daughter of Mrs Devine, that the police had received the decision from the CPS, therefore denying the police the opportunity to discuss the decision with the CPS beforehand. In fact, it appears that no liaison took place between the police and the CPS regarding the outcome of the CPS decision.

Contact with families during the investigations

5.250 In the course of the third investigation, Hampshire Constabulary recognised that a family liaison strategy had been lacking and the families' confidence in the police investigation had been dented. By November 2002, a large number of families were being represented by Ann Alexander (Solicitors) (HCO004764, HCO003041). Ann Alexander's involvement brought about the establishment of family group meetings, some of which Hampshire Constabulary attended to provide updates and answer questions for the families. The police also provided bulletins to the family group meetings (HCO000001). Mrs Mackenzie was represented by Ken White of Cornfield Law, with whom Hampshire Constabulary also kept in contact (HCO002246, p3). The police also telephoned and corresponded with Ann Alexander and family members in order to

provide updates and to answer any queries (HCO004767; HCO000639, pp38–40; HCO000639, pp93–100; HCO001980, pp4–5).

5.251 On 21 May 2004, a family liaison officer, Detective Constable (Det Con) Kate Robinson, was appointed to review existing arrangements and to take a family liaison strategy forward (HCO000640, p13). At this time, a report on the ongoing family liaison confirmed:

> "There are currently 79 main Family Group Members, who are the/joint point of contact for their family … The Family Group Members are kept informed of events which may impact on them by way of letter. ie change of address and contact numbers. When there are a number of items with which to update the Family Group, a bulletin is prepared and again sent by post." (HCO000640, p14)

5.252 It is clear from the documents that family members felt that Hampshire Constabulary's level of communication was inadequate (HCO002486, p3).

5.253 Following the decisions on prosecution in December 2006, the families affected were offered the opportunity to meet with the CPS and Counsel (CPS002008).

5.254 Following the conclusion of the third police investigation, poor family liaison was the subject of a complaint by Mrs Reeves to the Independent Police Complaints Commission (IPCC) in 2007. The IPCC independent investigator noted:

> "The issue over communication and Family Liaison provision was again part of Mrs Reeves' original complaint and was subject to investigation. This concluded in May 2006 with the recommendation that Superintendent James receives operational advice over his management of the victims' families. The issue over family liaison is raised in the review by Chief Superintendent Johnston, [Head of CID at] Avon and Somerset, and again in Assistant Chief Constable Cole's investigation report to the IPCC … the role of the FLO [Family Liaison Officer], amongst others, is to keep the family informed of the progress of the investigation and to act as a conduit between the investigation team and the complainant. During the period of the latest investigation with Detective Superintendent Williams in charge there is a mass of correspondence supplied by Mrs Reeves herself with letters and e-mails between herself, D/Supt Williams, Dep Ch Const Readhead and others answering the issues that she raises. Included are the 7 update bulletins that she received from Operation Rochester, the last being 18 February 2005 … In addition there is detail of contact that Mrs Reeves instigated with Kate Robinson on at least two occasions … Clearly there has been a breakdown of trust between Mrs Reeves and the Hampshire Constabulary, which has admitted failures in their Family Liaison Policy following the earlier investigation." (IPC100813, pp6–8)

5.255 The IPCC investigator concluded that the complaint of poor communication was unlikely to be substantiated (IPC100813, p8).

5.256 The Panel notes a paucity of information provided to and the sporadic nature of the family group meetings. There was a two-year delay in appointing a family liaison officer. There does not appear to be any rationale for not adopting a family liaison strategy far earlier than 2004. Despite the appointment of a family liaison officer, families lost confidence in the police.

5.257 The Panel has not seen documents relating to the Family Liaison Policy File and therefore has been unable to consider the full extent of the family liaison records.

5.258 During the first year of the third police investigation, Det Ch Supt Watts applied for and accepted a place on a Strategic Command Course by 7 January 2004. This started a few weeks later. Although Det Ch Supt Watts would be attending the course full time, a decision was made that he would retain supervision over the investigation (HCO000640, pp88–90). The families expressed concern about this (FAM003222). The Panel has not seen any document that confirms how it was that Dep Ch Const Readhead agreed that Det Ch Supt Watts could retain 'overview' of the investigation in such circumstances. Dep Ch Const Readhead appeared not to recognise the families' perception that they were being failed and the subsequent impact this had on the confidence they had in his force. The Panel observes that the duration of a Strategic Command Course is approximately 12 months and considers this a long period of time to be away from a prolonged and complex investigation such as the third police investigation. The Panel has seen no documents to confirm Det Ch Const Readhead's rationale for allowing Det Ch Supt Watts to attend the Strategic Command Course while retaining the direction of a large-scale, complex and serious investigation, which had been declared a critical incident.

How the families' complaints against the police were investigated

5.259 Between 1998 and 2007, a number of complaints were made by family members regarding the conduct and management of the first, second and third police investigations. During that period, six investigations into police conduct were carried out and six reports were produced on various aspects of the three investigations. Additionally, the IPCC carried out one review of a complaint investigation and one complaint investigation of its own. The following is a summary of those complaints, investigations, reports and reviews.

Mrs Mackenzie's complaint

5.260 On 20 November 1998, during the first police investigation, Mrs Mackenzie made a complaint alleging that the investigation being undertaken by Det Con Maddison was flawed, not properly supervised, and that Det Insp Morgan had spoken to her in an inappropriate manner (HCO501756).

5.261 Since the investigation into the death of Mrs Richards was still being undertaken by Det Con Maddison, a decision was taken that the complaint investigation would be temporarily suspended pending the outcome of the criminal investigation (HCO501779, HCO501784).

5.262 Following the conclusion of Det Con Maddison's investigation, a statement was taken from Mrs Mackenzie (HCO501805, pp3–11). Regulation 9 notices were served on Det Insp Morgan and Det Con Maddison in February and May 1999 (HCO501774; HCO501805, p17; HCO501805, p19).

5.263 The notice to Det Insp Morgan alleged that during a telephone conversation Det Insp Morgan was aggressive, uncivil and unprofessional towards Mrs Mackenzie, that Det Insp Morgan had also misled Mrs Mackenzie regarding the submission of papers to the CPS, and that she had failed to supervise the investigation in a manner that ensured it was dealt with thoroughly.

5.264 The notice to Det Con Maddison alleged that, having been tasked to undertake an investigation, he had not properly carried out the investigation, that the investigation undertaken by him was flawed and failed to secure all available evidence, and that he had breached Mrs Mackenzie's confidentiality by informing a film crew of the facts of the case.

5.265 On 16 August 1999, Det Supt Longman provided a report to Ch Supt Basson ('the Longman report'), which confirmed that his terms of reference were to *"Review the investigation*

undertaken by officers from Gosport CID and report to the Head of Complaints and Discipline in respect of the quality and conduct of the investigation" (HCO501805, p20).

5.266 Det Supt Longman reached the following conclusions:

- "I believe that the seriousness of the allegations warranted, on receipt, overall responsibility for the investigation being taken by the Detective Inspector as Senior Investigating Officer, the use of a Policy Book to record the decision making processes and the use of a simple action based paper system to administer the enquiries."
- "Statements should have been obtained at an early stage from both Mrs. McKenzie and Mrs. Lack outlining their allegations and concerns."
- "Mrs. Lack's detailed notes should have been produced correctly with a proper explanation on how, when and where the notes were compiled."
- "Early efforts should have been made to secure and produce the relevant hospital notes. It is not clear if these have ever been in police possession."
- "Opinion should then have been obtained from an independent medical expert preferably in addition to the report obtained from Dr. Lord who has strong connections to Gosport Memorial Hospital."
- "This independent statement ideally should have contained best practice procedures in this sort of case together with a comparison of the treatment received by Mrs. Richards as recorded on her hospital notes commenting specifically on the lack of intravenous fluids during the period of syringe driver pain killing medication prior to her death … an interview should then have been arranged by appointment with Dr. Barton under caution where her response to the allegations should have been sought."
- "The papers should have then been submitted to the CPS for advice."
- "I do not think however that those enquiries would have altered the outcome or the decision of the CPS." (HCO501805, pp22–3)

5.267 On 18 August 1999, Det Ch Insp Burt was instructed to assume responsibility for the investigation to address the shortcomings that had been identified and pursue any other appropriate lines of enquiry (HCO000635, pp8–11).

5.268 By April 2000, Supt Stogden had decided, in agreement with Mrs Mackenzie, that her complaint would be held in abeyance pending the outcome of the second police investigation (HCO501733).

5.269 Superintendent (Supt) Adrian Whiting was appointed to take over from Supt Stogden as the Investigating Officer by 23 June 2000, and the complaint investigation was revived (HCO501818).

5.270 Det Con Maddison and Det Insp Morgan were first interviewed under caution on 11 October and 6 November 2000 respectively (HCO501805, pp26–72; HCO501805, pp73–101).

5.271 Mrs Mackenzie, dissatisfied with progress relating to her complaints, had contacted the PCA in November 2000 (HCO003653).

5.272 On 21 November, Ch Supt Basson, Head of the PSD, wrote to Mrs Mackenzie in response to her complaint and informed her that the PCA had no part to play in the complaint investigation at that stage. He apologised for the delay and confirmed that Supt Whiting would be in contact in due course (HCO501754). Some communication followed with Mrs Mackenzie (HCO501801, HCO501800, FAM004373).

5.273 On 17 January 2001, Supt Whiting submitted his report to Ch Supt Basson ('the Whiting report', HCO502128). The report concluded along similar lines to the Longman report and added:

> "… it would have been reasonable to have secured and produced the relevant hospital notes and medical records, even though at this stage no decision had been made about further prosecution action, such items would doubtless have been essential to the proceedings had any commenced at that point … the opinion obtained from Dr LORD was not as independent as ought to have been the case, and that this ought to have been clear from his [sic] report, where he sets out his responsibility for the ward." (HCO502128, p22)

5.274 Supt Whiting recommended that the most appropriate course of action would be to provide operational advice to both officers (HCO502128).

5.275 On 13 February, Dep Ch Const Readhead submitted his report to the PCA. His report concluded that the investigation *"had not found any part of Mrs Mackenzie's allegations to be founded and no impropriety had been found on the part of either officer"* and recommended that both officers receive operational advice (HCO501752).

5.276 The Panel notes that Dep Ch Const Readhead's report consists of three paragraphs and did not set out the exploration of events as recorded by Det Supt Longman and Supt Whiting. In this regard, the report lacks any detail around the investigation. With reference to the conclusions reached by Det Supt Longman and Supt Whiting, the Panel cannot see any basis for Dep Ch Const Readhead's report to the PCA that Mrs Mackenzie's allegations were unfounded.

5.277 On 13 March, the PCA endorsed Dep Ch Const Readhead's recommendation (HCO501746, p1). The PCA informed Mrs Mackenzie of the outcome (pp2–3).

5.278 On 26 March, Hampshire Constabulary's PSD sent a letter of apology to Mrs Mackenzie (HCO003359).

5.279 Det Con Maddison and Det Insp Morgan received operational advice. The Panel notes that the operational advice documents record that the complaints were not substantiated (HCO501742, HCO501741).

5.280 The complaint against Det Con Maddison and Det Insp Morgan was brought to a conclusion (HCO501795, p4).

Complaints against Detective Superintendent James

5.281 During 2002, eight families made complaints against Dep Supt James.

5.282 The complaints came from the following eight family members:

1. Ann Reeves, 15 April 2002 (HCO502213, HCO502230)
2. Marilyn Jackson, 30 April 2002 (HCO501929, HCO501928)
3. M E Wilson, 30 April 2002 (HCO502334)
4. Gillian Mackenzie, 1 May 2002 (HCO502102, HCO502127)
5. Marjorie Bulbeck, 7 May 2002 (HCO502278, HCO502291, HCO502292)
6. Barney Page, 29 May 2002 (HCO502211, HCO502209)
7. Iain Wilson, 3 June 2002 (HCO502253; HCO502349)
8. Charles Stewart-Farthing, 28 June 2002 (HCO502054).

5.283 The Panel has not seen any documents to confirm that any significant follow-up action or investigation was undertaken in respect of Professor Livesley's complaint.

5.284 The complaints from the above family members variously alleged the failure by Det Supt James to: (i) adequately investigate a serious allegation of crime; (ii) adequately communicate during the course of the investigation; (iii) obtain witness statements; (iv) communicate with families; and (v) provide the expert's reports.

5.285 In addition, the complaints alleged that Det Supt James had: (vi) acted in a conflict of interest by running a private business that could have impacted on the outcome of the investigation; (vii) provided misleading information; and (viii) obtained confidential medical material without consent.

5.286 Ch Supt Clacher was appointed to investigate the complaints (HCO502217). On 9 May 2002, he provided his first report to Dep Ch Const Readhead (HCO501918). The report addressed two specific issues; namely, the complaint made against Det Supt James and the desire for a further investigation. The report emphasised that the families felt hostility towards the police and that there was an apparent lack of impartiality between the police investigation and the complaint investigation process. Ch Supt Clacher concluded his report with the following recommendations:

- A complaint should be recorded against Det Supt James.
- A (possibly) external Investigating Officer should be appointed to investigate the complaint.
- The PCA should be informed and consulted about the complaint.
- The allegations should be reviewed (perhaps) by an external police force.

5.287 On 22 May, a Regulation 9 notice was served on Det Supt James. The allegation recorded in the notice alleged that the level of contact and communication with the complainants fell well below what should have been expected. No other allegations were included.

5.288 It appears that, following the report by Ch Supt Clacher, a decision had been made either by Dep Ch Const Readhead or Ch Supt Stevens (PSD) to limit the scope of the complaint investigation so that it did not include the alleged inadequate investigation.

5.289 During his investigation, Ch Supt Clacher liaised with the PSD and more often directly with Dep Ch Const Readhead (HCO501914, HCO502470).

5.290 Asst Ch Const Jacobs was appointed to provide oversight of Ch Supt Clacher's investigation. This was because of the need to have oversight by an officer senior to the officer under investigation.

5.291 On 19 June, Det Supt James provided a report addressed to Ch Supt Stevens entitled *"Operation Rochester – Complainant Mr Ian Wilson"*. The content of the report was related to a telephone conversation between Det Supt James and Iain Wilson on 24 May 2002, that being before Mr Wilson had lodged his complaint. Det Supt James concluded his report with the following comments:

- "That his, and/or the other complainants, motivation in registering complaints against me has the explicit intention of undermining my professional integrity within the organization."
- "That his, and/or the other complainants, motivation and intention in pursuing complaints is, in part, to have me removed from any responsibility for Operation Rochester and another SIO appointed."
- "That the highly personal nature of the repeated remarks that he and/or the other complainants seek an outcome that would 'destroy my career' I find disturbing."
- "I did during my career break from the Force have a properly declared business interest in providing care for adults with learning disabilities. That interest was declared before I commenced the career break. I no longer have any interest in that business which is small scale and owned entirely by my parents-in-law." (HCO502255, pp1–3)

5.292 Ch Supt Clacher and Dep Ch Const Readhead were informed about Det Supt James's report and the nature of his outside business interests.

5.293 On 29 May 2002, Ch Supt Clacher emailed Dep Ch Const Readhead directly, indicating that a persuasive argument was being made to reopen the investigation and obtain detailed witness statements from all material witnesses. However, he recognised the considerable difficulties this could cause to both the Hampshire and Isle of Wight SHA and Hampshire Constabulary and suggested an alternative way forward, with the PCA directing a review by an outside police force and conducting a new police investigation. Ch Supt Clacher highlighted the need to act sooner rather than later to avoid growing criticism from the complainants and to provide the answers they were seeking (HCO502470).

5.294 On 27 June, Ch Supt Clacher provided an interim report to Ch Supt Stevens. He expressed surprise at Det Supt James's contact with Iain Wilson and advised that this might be investigated in future. He advised against any future contact with any of the complainants (HCO502258). This recommendation prompted a response from Dep Ch Const Readhead who wrote to Det Supt James on 9 July advising against any further contact with the complainants.

5.295 On 21 July, Ch Supt Clacher provided his final report to Asst Ch Const Jacobs and Dep Ch Const Readhead ('the Clacher report'). While recognising that each complainant had specific grievances, his report identified the following common points:

- "The enquiry into the death of their elderly relatives was not conducted diligently or professionally and failed to take into account all of the evidence available."
- "… the police failed to keep the complainants appraised of the conduct and progress of the enquiry".
- "… no witness statements, material to the circumstances surrounding the deaths of their relatives, were ever sought or taken".
- "… having made the decision to discontinue enquiries, John JAMES indicated by letter that he would be releasing expert witness reports about the case and treatment of the deceased parties, only to withdraw that offer following two meetings at Fratton Police Station in February 2002". (HCO501909, p2)

5.296 The Clacher report set out the evidence that supported the above allegations while recognising that the complaint investigation was incomplete. In particular, no police officer, including Det Supt James, had been interviewed regarding their actions, and no policies or decisions in respect of the documentation were reviewed within the report. In this regard, it concluded: *"It would therefore be premature to arrive at any firm conclusion as to whether any discipline breaches have occurred. The only reasonable assumption to come at this stage is that there is a case to answer"* (HCO501909, p23).

5.297 The Clacher report concluded with the following recommendations:

- additional matters to be reconsidered by the Head of PSD regarding further Regulation 9 notices to be served on Supt James (p26)
- consideration needed on whether to inform the PCA, if it appears that supervising officers were responsible for directing the conduct of the enquiry, particularly after 19 June 2001
- *"a Senior Investigating officer be appointed from an outside force to fully investigate professional standards issues raised"*
- *"Outside force be invited to review the handling and decision making process in the Richards case as well as subsequent matters reported to the constabulary in April 2001"* (p27)
- *"the PCA be consulted and informed about the nature of the complaints"*
- in an Addendum, Professor Livesley to be seen to establish the nature of his allegation.

5.298 Dep Ch Const Readhead concluded that, following consultation with Asst Ch Const Smith and Det Ch Supt Watts, it had become apparent that the additional evidence obtained by Det Supt James during his investigation had not been subject to analysis by the CPS, although both Det Ch Supt Watts and Asst Ch Const Smith thought that it had been (HCO502057).

5.299 On 23 July 2002, Dep Ch Const Readhead wrote to Mr Daw at the CPS outlining the investigation and the failure to refer four investigation files to the CPS for review (HCO502056).

5.300 On the same day, Dep Ch Const Readhead also wrote to Asst Ch Const Jacobs, Ch Supt Stevens, Ch Supt Clacher and Det Supt Stickler, setting out the following actions:

- "To consider the service of additional, or more detailed, Regulation 9 Forms to be served on Chief Superintendent John James. ACC 'TO' to consider and action after CPS have reviewed all the evidence."
- "That an early assessment is made as to whether the Police Authority should be informed of the ' detail of this complaint and if supervising officers were responsible for directing the conduct of the enquiry. DCC to progress on return from annual leave."
- "That an SIO is appointed from outside the Force to fully investigate Professional Standards issues raised on the Case to Answer Sheet. Not at this stage."
- "That an outside Force be invited to review the handling and decision making processes in the Richards' Case. Not at this stage."
- "That the PCA be informed and consulted about the nature of these complaints. Not at this stage." (HCO502057, p1)

5.301 Dep Ch Const Readhead decided to await the response from the CPS before concluding the investigation into the complaints against Det Supt (now Detective Chief Superintendent) James (HCO502018, p3).

5.302 Det Supt Stickler was subsequently instructed to gather all of the evidence relating to the other four cases and pass it to the CPS. It was made clear to him and to the families that this would not be a reinvestigation of the cases considered by Det Ch Supt James and no new evidence would be gathered (HCO502080, p1).

5.303 In August and September 2002, several families wrote to Hampshire Constabulary, the PCA, the Attorney General, the Director of Public Prosecutions and a number of parliamentary offices to express their dissatisfaction with the state of affairs (for example, HCO502075).

5.304 On 1 September 2002, Det Ch Supt James wrote to Dep Ch Const Readhead to explain his understanding of what had taken place in relation to the failure to refer the four additional cases to the CPS. Dep Ch Const Readhead acknowledged that this decision was made by Det Ch Supt James alone, and that his failure to communicate his decision to senior officers was not due to any intention to deliberately or inadvertently mislead the senior command within Hampshire Constabulary (HCO501991, pp2–3).

5.305 On 18 November, Asst Ch Const Jacobs and Dep Ch Const Readhead agreed not to delay the complaint investigation any further. Subsequently, a new Regulation 9 notice was served to Det Ch Supt James on 25 November 2002. The allegations contained in the notice were as follows:

> "(a) On 21 May 2001 you were appointed Senior Investigating Officer in respect of Operation 'Rochester'. The subsequent enquiries into the deaths of elderly relatives of Mrs Jackson, Mrs Bulbeck, Mrs Mackenzie, Mr Page, Mrs Reeves Mr I Wilson and Mr M Wilson, were not conducted diligently or professionally and the investigation failed to take into account all of the evidence available.

> (b) During the course of the enquiries you failed to keep the relatives mentioned at (a) above appraised of the conduct and progress of the enquiry.
>
> (c) That no witness statements, material to the circumstances of the deaths of their relatives were ever sought or taken from those people mentioned in (a) above.
>
> (d) Having made a decision on the 28th January 2002 to discontinue the enquiries into deaths at Gosport War Memorial Hospital you indicated that you would release expert witness reports about the case and the treatment of the deceased parties to the relatives of the deceased persons … you subsequently withdrew this offer …" (HCO501964, p1)

5.306 On 31 January 2003, Det Ch Supt James submitted a written statement. He was not interviewed. The statement was detailed and provided a chronology of his investigation and responses to the complaints (HCO501911, pp1–57).

5.307 On 19 February, Asst Ch Const Jacobs confirmed that he was now in a position to finalise his review and prepare a report with recommendations for the PCA (HCO502120).

5.308 Around 25 March, Asst Ch Const Jacobs supplied a written report (IPC100115, p741) ('the Jacobs report') (pp743–58). The complaint by Iain Wilson was noted as withdrawn (p744). The allegation against Det Ch Supt James was noted as a complaint that his *"level of communication with them fell below what would be expected"* (p745).

5.309 Asst Ch Const Jacobs concluded that in his opinion any decisions made by Det Ch Supt James were *"taken in the honest belief they were correct and justified"* (IPC100115, p757). No evidence was supplied to support this claim other than what is stated by Det Ch Supt James in his statement. Asst Ch Const Jacobs recommended that *"no further action"* should be taken regarding *"these matters"* (p757).

5.310 Asst Ch Const Jacob's report presented the allegation as relating to the level of communication with the families but did not include the other complaints raised in the Regulation 9 notice dated 25 November 2002. Asst Ch Const Jacobs did not appear to question any decisions made by Det Ch Supt James during the investigation. The report seemingly accepts, as fact, Det Ch Supt James's statement.

5.311 With regard to the complaints about lack of communication, Asst Ch Const Jacobs concluded: *"It is the responsibility of the Senior Investigating Officer to ensure appropriate communication is made … The appointment of a Family Liaison Officer would have established effective lines of communication; this was not done."* He also noted that Det Ch Supt James had acknowledged that some of the complainants were not kept appropriately up to date (IPC100115, pp757–8).

5.312 Asst Ch Const Jacobs did not address the rescinded offer to the families to disclose expert reports and the failure to inform senior officers about the decision not to refer the four investigation files to the CPS.

5.313 The Jacobs report concluded with a recommendation that Det Ch Supt James should receive operational advice (IPC100115, p758).

5.314 On 26 March, Hampshire Constabulary reported to the PCA that the complaint against Det Ch Supt James related to poor communication, and made no reference to the other allegations of inadequate investigation. The report to the PCA effectively consisted of two

paragraphs and recommended that Det Ch Supt James receive operational advice with regards to these matters (HCO501962).

5.315 On 31 March, Ch Supt Stevens informed Det Ch Supt James by telephone of the recommendation to the PCA, but with the caveat that the PCA might change that outcome (HCO502420).

5.316 On 3 April 2003, Emily Yeats, Mrs Wilkie's granddaughter, wrote to the PCA and alleged that, during a telephone conversation on 1 April 2002, Ch Supt Stevens had advised her that the PCA would 'rubber-stamp' the recommendations in ACC Jacobs' report. Emily Yeats expressed shock at the recommendation and concern that the PCA, an independent body, would 'rubber-stamp' the recommendations. She requested that the PCA examine the case carefully (HCO502032).

5.317 Ch Supt Stevens subsequently issued update letters to the complainants, taking care to explain that the role of the PCA was to undertake a misconduct review and that it had responsibility for providing quality assurance of the complaint investigation and the recommendations (for example, HCO502090).

5.318 On 19 June 2003, Alison MacDougall of the PCA contacted Dep Ch Const Readhead by letter. She explained that the complaint investigation was incomplete and that several issues highlighted within the Clacher report remained unresolved. Alison MacDougall suggested that the recommendations within the Clacher report be adopted (HCO502033).

5.319 On 9 July, Dep Ch Const Readhead responded by letter. He confirmed that documentation would be provided to address some of the issues raised by the PCA. He also explained that an ongoing criminal investigation was being undertaken under the direction of Asst Ch Const Smith and the Major Crime Investigation Team. He asserted that *"at no stage"* were the words *"rubber stamped"* used as had been alleged (HCO502034, p2). Dep Ch Const Readhead also informed the PCA that Det Ch Supt James had never been connected with a care home for disabled children, nor on a regular basis was liaising with members of the *"Local Health Trust"* or members of the medical establishment (p2). This was not correct. Det Ch Supt James had previously acknowledged that, during his 12-month career break, he had helped his in-laws set up a care home for disabled adults and children. The Panel therefore notes that, during that period, he might have been in contact with medical professionals.

5.320 It is not clear why Dep Ch Const Readhead apparently misinformed the PCA in this regard.

5.321 On 20 July, Det Insp Mike Dodds compiled a report. This appears to have been prepared in response to the PCA's request for additional information. Det Insp Dodds concluded that he was unable to comment upon judgements made by Det Ch Supt James and recommended that Det Ch Supt Watts should be asked to comment (HCO502035).

5.322 In turn, Dep Ch Const Readhead offered the PCA an opportunity to meet with members of the current Operation Rochester team as well as the PSD team to enable the PCA to reach a conclusion.

5.323 An internal PCA memo from Alison MacDougall to Ian Bynoe highlighted that Hampshire Constabulary had not addressed the outstanding complaints, and that: *"on the face of it the recommendation of advice about poor communication seems a completely inadequate response. The flavour of the SIO's actions seems to be, to direct the problem towards a CHI investigation after the police ran into problems with their first expert"* (IPC100115, p108).

Mr Bynoe in his response of 10 September was very critical of the Jacobs report and indicated a lack of diligence in the complaint investigation. Mr Bynoe also raised a concern about the potential issue regarding Ch Supt James and his external business interests. Mr Bynoe agreed that a review of the complaint by an external force should be a major consideration as the complainants had little confidence in the Assistant Chief Constable. He concluded that the Jacobs report *"does not address issues of neglect, diligence and compliance with current homicide investigations"* (IPC100115, p104).

5.324 Mr Bynoe suggested that it was too late for formal supervision of an ongoing investigation; however, the professional standards issues should be the subject of a review. Mr Bynoe recognised that Dep Ch Const Readhead wanted to keep control of the issue and did not want to refer the investigation to an outside body (IPC100115, pp103–4).

5.325 On 11 September, a meeting took place between Alison MacDougall and Dep Ch Const Readhead. The note of the meeting records that Dep Ch Const Readhead had been anxious to resolve the outstanding issues. Matters included the decisions made by Ch Supt James and his discussion with Counsel at a *"Treasury Counsel meeting"*. When Alison MacDougall enquired as to the precise nature of this conversation, *"Mr Readhead explained that the rule about it was that no notes were allowed to be taken"* (HCO005270, pp12–13). It was agreed that a suitable SIO would be appointed to review the adequacy of Det Ch Supt James's investigation (IPC100115, pp101–2).

5.326 Chief Superintendent (Ch Supt) David Johnston, Head of CID at Avon and Somerset Constabulary, was subsequently appointed to undertake a review of Det Ch Supt James's investigation. On 1 December, Alison MacDougall informed all interested parties of the review by letter (HCO502038).

5.327 On 1 December, the following terms of reference were agreed between Avon and Somerset Constabulary and the PCA:

- "Examine the actions taken, and the investigation conducted following the original report in 1998 by Mrs Mackenzie; and to consider whether the response with the known information at the time was appropriate."
- "… further review the wider inquiry conducted by Det Supt James between May 2001 and January 2002, and advise on the appropriateness of that investigation, given the information known at the time". (HCO502038, p3)

5.328 The agreed terms of reference indicated that the PCA was at that stage not content that a robust complaint investigation had been conducted, which adequately addressed all issues raised by the complainants.

5.329 On 8 January 2004, a meeting between Alison MacDougall and Ch Supt Johnston took place. The note of the meeting indicated that Ch Supt Johnston and colleagues had spent several days in Hampshire reviewing material. The overall conclusion was that Det Ch Supt James's investigation was inadequate (IPC100115, pp89–90). The note indicated the following:

- Det Ch Insp Burt had supported the widening of the enquiry but that this was prevented.
- The investigative strategy was almost entirely lacking with no clear terms of reference.
- Det Ch Supt James oversaw the investigation conducted by Det Ch Insp Burt and did not undertake any review when he took over.

- Policy Files lacked detail, particularly in relation to key decisions about not taking action.
- It was unclear who made the decision to close the investigation. Det Ch Supt James had indicated that he was told to close it; however, there were no documents available to support this.
- No notes of meetings between Hampshire Constabulary, Counsel and the CPS regarding Professor Livesley's report could be found.

5.330 On 2 February, Ch Supt Johnston provided his report to the PCA ('the Johnston report', HCO501982).

5.331 Within paragraph 21 and 22 of his report, Ch Supt Johnston was critical of the Policy Books created by Det Ch Insp Burt and questioned the integrity of the books.

5.332 Ch Supt Johnston recorded on several occasions that decisions, apparently documented by Det Ch Insp Burt, appeared to indicate that senior influence was being applied. Paragraphs 30 to 32 of the Johnston report provide a full summary of the issues that Ch Supt Johnston identified with the Burt investigation.

5.333 From paragraph 33 onwards, Ch Supt Johnston provided observations on the actions of Det Ch Supt James. He found that Det Ch Supt James had not undertaken or instigated a review of the case on taking control. No family liaison officer had been appointed. Policy Books for both Det Ch Insp Burt and Det Ch Supt James failed to comply with guidance. The investigation conducted by Det Ch Supt James was not carried out with sufficient depth or quality given the facts known at the time.

5.334 Ch Supt Johnston observed: *"It is clear … that D/Supt JAMES was following some unwritten policy from the corporate entity of the force. Notwithstanding this, he had a duty as the SIO and failed to effectively perform that duty to investigate allegations of serious crime"* (p18).

5.335 On 12 February, Dep Ch Const Readhead sent an internal memo to Ch Supt Stevens (PSD) requesting that Assistant Chief Constable (Asst Ch Const) Simon Cole act on behalf of the Hampshire Constabulary (HCO501976). The appointment of Asst Ch Const Cole was approved by the PCA on 23 February. On 3 March, Asst Ch Const Cole was supplied with the relevant documents in order to undertake his role (HCO501960).

5.336 Dep Ch Const Readhead had indicated that there might be a possible need to reconsider the ongoing criminal investigation if it became apparent that Det Ch Supt Watts and/or Asst Ch Const Smith had influenced the previous investigation conducted by Det Ch Supt James.

5.337 The IPCC was due to take over the PCA and become operational on 1 April 2004. The records indicate that Dep Ch Const Readhead contacted and met with Laurence Lustgarten, the new IPCC Commissioner with responsibility for Hampshire (HCO502200, p1). The Panel has not seen any documents to confirm the reason for the meeting.

5.338 On 5 April, Det Ch Supt James was served with a new Regulation 9 notice. The notice records the complaint as follows:

> "That the investigation into the deaths at Gosport War Memorial Hospital reported to Hampshire Constabulary by the complainants, and for which you were the Senior Investigating Officer, were not conducted effectively and thoroughly and in accordance with guidance issued to SIO's in the MIRSAP Manual of Guidance.

It is also alleged that you failed to keep the families fully updated as to the progress of the investigation, key investigative milestones, or significant decisions affecting the process of the investigation.

Whilst not specifically alleged by the complainant, an independent review conducted by an officer from Avon and Somerset Constabulary, suggests that the investigation was lacking in the following areas:

You did not arrange for an independent review of the investigation, the absence of which is contrary to the guidance included in the MIRSAP Manual of Guidance to SIO's;

You did not establish clear terms of reference or an investigative strategy;

You did not deploy Family Liaison Officers, which led to a break down in the communication process between the SIO and the families;

Your policy books did not comply with guidance contained in the MIRSAP Manual of Guidance;

There was a lack of structure relating to the construction of strategy and policy on issues such as Forensic matters, Suspect Categories, witnesses, finance and set up;

The investigation was not carried out with sufficient depth or quality;

Failing to engage the ten families who reported concerns." (HCO501978, p1)

"That you failed to investigate these complaints and failed to forward a file of evidence to the CPS and Counsel for consideration, based upon the failure of the Richards case. It is alleged that this was a flawed decision.

That you were working to an 'unwritten policy' possibly emanating from the 'corporate entity of the force', and therefore failed in your duty as an SIO to effectively perform that duty to investigate allegations of serious crime." (HCO501979, p1)

5.339 On 12 July, Det Ch Supt James responded to the allegations with a written statement. He was not interviewed. The first 12 pages of his statement appear to address issues related to Det Ch Insp Burt's investigation. Det Ch Supt James explained in detail his appointment as SIO of Operation Rochester and the limitations placed upon him as a result of operational and manpower constraints (HCO501981). His statement concluded with the following:

"I believe that I acted professionally, responsibly and with integrity throughout my tenure as SIO for Operation Rochester. I acknowledge, with the benefit of hindsight, that some aspects of the investigation fell short of the very high standards that I set for myself. I would assert that I was seeking to balance throughout my tenure as SIO a range of competing interests in a complex matter with, at times, inadequate information. There was no organisational guidance for investigations of this nature and I was making decisions based upon the best judgments at the time. I would suggest that there is personal and organisational learning from every investigation and that this should be taken into account when considering the responses I have provided to the allegations made." (HCO501981, p38)

5.340 Asst Ch Const Cole provided an undated report to Dep Ch Const Readhead (HCO502061). It concluded that nothing within this report changed the validity of the previous recommendations that Asst Ch Const Jacobs and Ch Supt James should receive operational advice (HCO502061, p6).

5.341 It is not clear whether Asst Ch Const Cole had sight of the Clacher report at any stage.

5.342 On 15 June 2005, Dep Ch Const Readhead wrote to the Hampshire Police Authority. In his letter, he expressed criticism of the IPCC for the time it had taken to deal with the matter and stated:

> "As fate would have it Chief Superintendent James has decided to retire from the police service and his last working day will be at the end of August. I have deliberately not advised the IPCC of this information as it should have no impact upon their conclusions with regard to the complaint investigation. Nonetheless on the basis of their historical speed of concluding issues I anticipate that Chief Superintendent James will have left the police service before they actually reach any decision which of course will nullify any conclusion that they may reach. I sense that the original complainants' may feel thwarted that the matter was not resolved within a sensible length of time. I am grateful for the authority's support on this matter and will of course brief members at the next complaints panel meeting." (HCO502044, pp1–2)

5.343 On 22 June, the IPCC learned that Det Ch Supt James *"had handed in his resignation"* and expressed the need to deal with matters urgently to avoid accusations that the IPCC waited until James had left before concluding the investigation (IPC100115, p302).

5.344 On 28 June, the IPCC submitted provisional decision letters to each of the complainants and also to Hampshire Constabulary (IPC100115, pp21–9). By that time, the IPCC decision was that the only complaint which was substantiated was that Det Ch Supt James *"failed to implement a communication strategy between the force and the affected families"* and that the IPCC was minded to agree with the recommendation that the officer receive operational advice with regard to the communications failings (p25).

5.345 The complainants responded expressing dissatisfaction with the IPCC outcome. They voiced concerns and a feeling of a loss of trust in the organisation. Mrs Reeves suggested that the process had simply been a rubber-stamping exercise (IPC100115, pp289–90).

5.346 On 20 October, an internal IPCC email was sent by the allocated case worker at the IPCC. Her email highlighted the anger displayed by complainants, who had only just found out that Det Ch Supt James had retired before the complaint had been finalised. The email raised concerns that the complainants would be going to the press and that this action would seriously damage the reputation of the IPCC. It also raised concerns about the handling of the complaint and concluded that the case file did not conform with procedures for a misconduct review and that the IPCC could potentially be legally challenged. The case worker finished by stating that the Commissioner handling the case (Mr Lustgarten) had not kept her updated on progress and had been communicating directly with the force and the complainants without informing her. The final paragraph of the email indicated that a new, separate complaint had been made by Mrs Mackenzie and was being investigated by the IPCC (IPC100115, pp270–1).

5.347 On 21 October, the IPCC released a press statement publicly apologising to six complainants, indicating a number of problems with the handling of the complaints (IPC100115, p233). The press release generated emails from the complainants expressing

their dissatisfaction with the IPCC. Following the emails, it was again agreed that no formal conclusion of the case would occur before full consultation had been achieved with the complainants (IPC100115).

5.348 On 21 November, a letter to the complainants confirmed that a decision had been made to reallocate the case to another IPCC Commissioner (Rebecca Marsh) and a new case work manager, both working out of the Cardiff office. The letter concluded with the IPCC accepting that the handling of the complaint to date had fallen below their usual high standards. Arrangements were then put in place to attempt to meet with the complainants (IPC100115, p19).

5.349 In an attempt to address the issues, the IPCC tried to locate missing documentation from Hampshire Constabulary (HCO502188, HCO502189).

5.350 Individual confidential meetings were held with the complainants at a hotel in Gosport on 23 February 2006 (IPC101003, IPC100999, IPC101002, IPC100998, IPC101004) and 13 March (IPC100281). Final decision letters were sent to the complainants on 19 March.

5.351 The letters stated:

> "I explained that your complaint was dealt with under the Police Act 1996 which meant that the PCA (Police Complaints Authority) and latterly the IPCC had limited powers to deal with such complaints and had no powers to investigate, i.e. only had the powers to agree or disagree with the discipline recommendations made by the force on a misconduct review case. With the advent of the IPCC on 1 April 2004, new legislation came into force (Police Reform Act 2002), which afforded us wider and more comprehensive powers than the PCA. Unfortunately, the new legislation is very clear and does not allow us to invoke powers where the complaint relates to an incident covered under the old legislation. New complaints, i.e. those complaints that were never identified prior to 1 April 2004, may be dealt with, but they would only be dealt with under the old legislation. Any 'new' complaints relating to complaints after 1 April 2004 may be subject to the new legislation providing they fulfil the legislative criteria. I think that it is important to distinguish at this stage the difference, as you may wish to make new complaints and you should understand what powers the IPCC would have to deal with them. As we discussed, you had expectations of a higher discipline outcome for the officer. I must inform you that I am hereby confirming the provisional decision, outlined in the letter to you dated 28 June 2005. I know that this is not the outcome that you were hoping for, but I can assure you that a full and comprehensive review of all the documents and information relating to your complaint has been conducted and that the outcome as detailed in our previous letter is appropriate in terms of the powers available to us – that is to determine whether there is a realistic prospect of showing that the officer's behavior has fallen below the standards set out in the Police Code of Conduct. This has to be proved on a balance of probabilities, which means that the tribunal must decide that it is more likely than not that an allegation is true. In this case, we do not believe a panel would find that the officer's conduct fell below the required standards and therefore a higher discipline outcome would not be forthcoming. You raised the issue of the officer's retirement and promotion. I would reiterate that the IPCC, and formerly the PCA, would not have had any influence over the officer's retirement whilst having an outstanding complaint. Even if a criminal charge were outstanding against the officer he may still have been able to leave the force and would then be subject to the findings of a criminal

court. Retirement is a matter for the force and the officer." (IPC100537, IPC101047, IPC101048, IPC101051, IPC101052, IPC101053)

Complaint against Detective Superintendent Williams and others

5.352 Following the conclusion of the IPCC review of Det Ch Supt James's investigation, Mrs Mackenzie raised complaints about failures in the ongoing investigation being conducted by Det Supt Williams. A new investigation into Mrs Mackenzie's new complaint was commenced (IPC101193).

5.353 The Panel has not seen any documents to confirm the full extent and outcome of this investigation.

5.354 However, during the Coroner's inquest regarding the death of Mrs Richards, Mrs Mackenzie gave evidence on 12 May 2013, and provided an explanation as to why the investigation ended. She said:

> "All my complaints against the police, as you know, have been upheld. When it got to 2004 and I was able to … [inaudible] on which of course I could not comment I did go to the IPCC to make a further complaint. It took four hours and I said I hoped they would record it (which they didn't do) and then about six or seven weeks later I was told they couldn't read their shorthand and I am afraid I gave up at that stage." (PCO001778, p16)

5.355 In 2006, Mrs Reeves also lodged a complaint against Det Supt Williams, Det Con Robinson, Dep Ch Const Readhead, and a formal complaint against the Chief Constable of Hampshire over his lack of direction and control (IPC100697, IPC000055, IPC100119, IPC100632).

5.356 On receipt of Mrs Reeves' complaint, the IPCC noted:

> "The whole situation with the investigation into the Gosport War Memorial Hospital is very complex and has been a prolonged affair involving many different bodies, agencies and changes in legislation. Hampshire Constabulary are on their third Operation Rochester Investigation … The Family liaison strategy has been poor and it seems a defensive position has been taken in correspondence from the force to the families, in particular with Mrs Reeves and latterly with Mrs Graham. The complaints now made formally by Mrs Reeves are of sufficient seriousness to undermine public confidence in the police and require an appropriate degree of action by the IPCC … Paul Close at the CPS has indicated to Mrs Reeves that information given to her by Hampshire about the progression of the file to CPS is not correct. He has also indicated he would cooperate with an IPCC investigation and this may highlight other failings on the part of the force. Paul Close has been spoken to by Peter Miller and he has indicated that at this stage he cannot comment to us, as the files are currently under consideration by CPS and it would not be appropriate to do so … Given the high level of public interest in the case, the clear repeated failures of the force in communicating with and supporting the complainants through each phase of the reinvestigations, together with the clear evidence provided, I believe that the IPCC should call in the complaints and an investigation should be conducted independently … This would be the most appropriate option and need not be resource intensive given that much of the evidence would be 'paper trailed'. It would be an opportunity to restore some public confidence in the police and would give the

> IPCC the opportunity to tackle issues with one of the worst performing police forces in the country." (IPC100667, pp1–3)

5.357 The IPCC commenced an investigation into Mrs Reeves' complaint (IPC100006, pp62–72):

> "An IPCC strategy meeting [was] convened on 5th December 2006 to include the IPCC Commissioner Rebecca Marsh and Regional Director Jane Farleigh to discuss the detail of the new complaints from Mrs Reeves and agree how any investigation will proceed." (IPC100119, p1)

5.358 In November 2006, Paul Davies was appointed as the Investigating Officer and he started a Policy Decision Book (IPC000086, p9).

5.359 Following the CPS decision in December 2006 that there would be no prosecutions, Mrs Reeves lodged further complaints that some of the evidence she had presented to Hampshire Constabulary regarding her mother's state of health had not been passed to the CPS (IPC000021). On 14 February 2007, an internal email between Mr Bynoe and Mr Davies (IPCC) identified that they felt that the IPCC held sufficient information on which to reach a decision (IPC100019).

5.360 On 22 March 2007, Mr Davies provided his final report concluding his investigation (IPC100179).

5.361 On 29 March, a letter from Mr Bynoe to Ch Supt David Peacock (PSD) provided a copy of the final IPCC report and requested proposals on how to deal with the recommendations contained within the report (IPC100006, p7).

5.362 On 23 April, Ch Supt Peacock responded as follows:

> "I have now had the opportunity to review the file and can confirm that, following consultation with Deputy Chief Constable Ian Readhead, the Constabulary make the following proposals under Schedule 3, paragraph 23 (7) of the Police Reform Act 2002 in relation to the complaints, as listed and made by Mrs Reeves:
>
> 1-3) No disciplinary action will be taken against David Williamson. This decision being based on the outcome that the complaints have not been substantiated.
>
> 4) No disciplinary action will be taken against Constable Kate Robinson. However, in accordance with the IPCC recommendation, Detective Superintendent Williams will be tasked to undertake a structured de-brief of Operation Rochester. This will seek to identify good practice and highlight any lessons that might be learnt, in particular relating to family liaison strategies. Constable Robinson will also be made aware of Mrs Reeves' criticisms and updated on any learning issues that are identified from the structured de brief.
>
> 5) No disciplinary action will be taken against Detective Superintendent Williams. This decision being based on the outcome that the complaint has not been substantiated.
>
> 6) No further action will be taken in respect of the generic complaint made against Hampshire Constabulary. However, it is accepted that the structured de-brief, referred to in paragraph 4 above, may identify measures that could avoid future situations where victims of crime are left confused over changes in procedures and protocols,

made during the course of an investigation, thereby leaving them with an unrealistic expectation of the Constabulary.

7) It is a matter for Hampshire Police Authority to determine any future actions, when considering the complaints made against Deputy Chief Constable Ian Readhead. However, the fact that the complaint was not substantiated is noted.

8) It is a matter for Hampshire Police Authority to determine any future actions, when considering the complaints made against Chief Constable Paul Kernaghan. However, the fact that the complaint has been deemed to be a direction and control matter is noted.

9) The recommendation made, relating to the manner in which the Crown Prosecution Service (CPS) decision, not to prosecute any individuals related to the Gosport Memorial Hospital, is noted. However, it is felt that the Constabulary did everything within its power to set a clear and precise strategy with the CPS but that this strategy was actually frustrated by internal differences within the CPS resulting in this unfortunate outcome. Therefore, whilst the Constabulary would welcome a joint review with the CPS on this point, it cannot accept the suggestion that a robust strategy, based on existing protocols, had not been adopted." (IPC100006, pp5–6)

5.363 On 31 May, the IPCC sent Mrs Reeves a copy of the final report. The letter identified that her complaints did not constitute breaches of the Police Code of Conduct. However, the report highlighted failures in certain areas and made recommendations. The covering letter informed Mrs Reeves that *"the report should be considered as final and there is no right of appeal"* (IPC100006, p3).

5.364 On 20 July, Mr Bynoe sent Ch Supt Peacock (PSD) a letter. It noted that the IPCC involvement in the matter was now at an end. It also confirmed that Mrs Reeves had received a copy of the final report and had made no comment on its content (IPC100006, p4).

5.365 The Panel is reminded that, during a family liaison meeting with Ann Alexander and Claire Amos of Alexander Harris Solicitors on 6 November 2002, Det Ch Supt Watts had stated that he had considered the investigative steps taken by Det Ch Supt James and that he was happy with the way in which Det Ch Supt James was conducting his investigation (HCO501718, p2).

Conclusion: what is added to public understanding

- **The nurses' concerns about the prescribing and administering of drugs at Gosport War Memorial Hospital ('the hospital') are described in Chapter 1 of this Report. The Panel has found no documents indicating that Hampshire Constabulary, the relevant police force, was made aware of these concerns. Nor do the papers show any approach to Hampshire Constabulary in the period up to 1998.**

- **Between 1998 and 2010, Hampshire Constabulary conducted three investigations and engaged with the Crown Prosecution Service.**

- **The documentation available to the Panel shows the action taken by the police to assess the validity of the concerns being raised by Gillian Mackenzie and Lesley Lack, Gladys Richards' daughters. The report by Detective Constable (Det Con) Richard Maddison consisted of a reiteration of the notes taken by Mrs Lack. Potential witnesses were not identified, no statements were taken, no contact was made with the hospital to secure**

clinical notes, records or evidence, or the investigation report by Lesley Humphrey (Director of Quality at Portsmouth HealthCare NHS Trust), which contained early accounts from nursing staff. No scene visit was undertaken, no forensic evidence was considered and no thought was given to the possibility of looking into other patient records for similar issues. Nor were any investigative steps taken to secure best evidence. This was particularly important given that Mrs Richards had been cremated and therefore could not be the subject of a post mortem and toxicology report. There was also no attempt to seek advice from the Crown Prosecution Service.

- There is nothing in the records to suggest that either the police or the Crown Prosecution Service considered the need to instruct Counsel for advice or reflected upon the inadequacy of this investigation. Nor is there any reference to the Code for Crown Prosecutors. The documents suggest that no consideration was given to the range of potential offences and defendants or to the possibility that there were other similar cases at the hospital.

- The documents do not show that Hampshire Constabulary made any consideration of steps they might have taken to address any ongoing risk to patients at the hospital. The police did not take action to identify the other cases that might have been involved and they continued with a paper-based investigation rather than switching to a computer-based HOLMES account as proposed in the briefing note. The papers do not show any consideration of establishing a Gold Group, through which the investigation could be effectively managed and coordinated.

- Professor Livesley completed his first report. In doing so, he made it clear that his report, dated 9 November 2000, was provided for discussion only and that he required a conference with the Crown Prosecution Service and Counsel before finalising his report. He expressed serious concern about what appeared to be *"a culture of inappropriate clinical practice"*.

- There is no evidence of the police taking any action to pursue Professor Livesley's recommendation in respect of other patients at the hospital or to consider issues of corporate liability.

- On 31 May 2001, David Perry QC advised, in writing, that having considered the case of Gladys Richards the *"evidence does not reveal the commission of any offence"*.

- Despite the concerns that had been raised by Professor Livesley, Dr Keith Mundy (consultant geriatrician) and Professor Gary Ford (a medical professor at Newcastle University), on 28 January 2002 Detective Superintendent James took the decision to end the police investigation, which he recorded as follows: *"SIO's decision re wider police investigation into deaths at Gosport War Memorial Hospital is that further investigation would not be appropriate"*. The reasons given for reaching this decision were the lapse of time since Det Con Maddison's initial report from 5 October 1998, the lack of evidence of any unlawfulness having occurred, conflict between experts, the lack of certainty of any particular outcome and the fact that other agencies (such as the General Medical Council) have a role.

- The Panel has seen no documents providing details of meetings, briefings or other considerations leading to the decision to close the second investigation. No closure report has been disclosed. Moreover, the documents indicate that the decision to end the investigation was not discussed with the Crown Prosecution Service.

- The documents show that there were a series of events described in this chapter that obliged Hampshire Constabulary to reverse their decision and to institute a further investigation.

- The documents confirm that, during the third investigation, new complaints and concerns relating to patient care and deaths at the hospital were reported to the police, who considered the deaths of 91 patients.

- The Panel has not seen any document to confirm on what basis the police determined that no offences had been committed in respect of the 1991 events. The Panel notes that the investigation into the 1991 events was incomplete in that the police had not sought to establish the specific details of the nurses' concerns, the chain of command on the wards and the hospital, and the persons responsible for implementing the use of syringe drivers and diamorphine. The police also did not enquire into staff training and senior-level knowledge and involvement in the response to the nurses' concerns. In addition, Hampshire Constabulary did not enquire into the result of the Strategic Health Authority-commissioned management investigation. Following the decision that no offences had been committed in respect of the 1991 documents, the police did not invite the Strategic Health Authority or Commission for Health Improvement to reinstate their investigation.

- Mr Perry's advice did not extend to the possibility that offences may have been committed by Dr Barton and others, including the Trust, under health and safety legislation. The Panel has seen no evidence to indicate that full consideration was given to whether such offences had been committed.

- The Panel notes that, during the course of all three investigations, the need to look into corporate liability and health and safety offences was brought to the attention of senior police personnel and the Crown Prosecution Service. Hampshire Constabulary sought legal advice on these issues but the documents suggest that neither the case for corporate prosecutions nor the case for bringing prosecutions under health and safety legislation was fully or properly considered.

- Throughout the three police investigations, a variety of evidence was obtained which, in the Panel's view, indicated that offences under the Health and Safety at Work Act 1974, and/or corporate manslaughter, might have been committed. Among other matters, Professor Livesley had raised the possibility that any wrongdoing might be wider than one patient and one doctor.

- As a general observation, the Panel notes that the more complex an investigation, and the greater the scale, the more likely it is that investigative advice and guidance will be required by the police from the Crown Prosecution Service. In a case as complex and novel as this one relating to the hospital, there may have been an increased need for regular and constructive liaison between the police and the Crown Prosecution Service but this does not appear to have been the case.

- It is clear from the documents that family members felt that Hampshire Constabulary's level of communication was inadequate.

Chapter 6: The General Medical Council

Introduction

6.1 The General Medical Council (GMC) is the only body that can remove a doctor from practice, suspend or place conditions upon a doctor's right to practise in the UK.

6.2 The GMC's primary role is to protect patients (GMC000504, p7). In 2002, the Medical Act 1983 was amended to insert section 1A (GMC101215, p211), which stated: *"The main objective of the General Council in exercising their functions is to protect, promote and maintain the health and safety of the public."* The overarching objective of the GMC is set out in primary legislation:

> "(1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.
>
> (1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—
>
> (a) to protect, promote and maintain the health, safety and well-being of the public,
>
> (b) to promote and maintain public confidence in the medical profession, and
>
> (c) to promote and maintain proper professional standards and conduct for members of that profession."

6.3 This chapter sets out what the documents reveal about the GMC's investigation into events at Gosport War Memorial Hospital ('the hospital') and the conduct of Dr Jane Barton, a clinical assistant. The background to the GMC's processes is provided in Appendix 2.

The GMC investigation: initial steps and first Interim Orders Committee

6.4 Concerns about events at the hospital were first brought to the attention of the GMC in 2000. There is no suggestion in the documents seen by the Gosport Independent Panel that the GMC was notified, either by the Royal College of Nursing or by the NHS, about the concerns expressed by nurses in 1991. Nor is there any suggestion that the GMC was notified by Hampshire Constabulary or Portsmouth HealthCare NHS Trust, or anyone else, when concerns were expressed about the death of Gladys Richards.

6.5 The first time the GMC was notified by any person or organisation about the concerns at the hospital was in a telephone call on 26 July 2000, followed by a letter the next day from Acting Detective Superintendent (Acting Det Supt) Raymond Burt (GMC101057, p1105). That

letter told the GMC, for the first time, that there was a police investigation following a complaint from the family of Mrs Richards, that she had been *"unlawfully killed as a result of treatment"*. The GMC was told *"the investigation is on going and no criminal charges have been preferred"*. The letter is headed *"Re: Dr Jane BARTON GP"* and goes on to say:

> "The doctor who appears to have been responsible for the care of Mrs RICHARDS at the time is Dr. Jane BARTON … who is a General Practitioner practising in Gosport, Hampshire. Dr. BARTON is additionally engaged by the Portsmouth Healthcare (NHS) Trust as a visiting Clinical Assistant at the GWMH." (GMC101057, p1105)

6.6 Dr Barton had in fact tendered her resignation from her role as a clinical assistant at the hospital on 28 April 2000 with a two-month notice period (GMC100891, p135).

6.7 There is nothing in the documents available to the Panel to show any contact between the police and the GMC between then and April 2001. On 30 March 2001, Hampshire Constabulary issued a press release saying that the investigation was complete and that a file had been passed to the Crown Prosecution Service (CPS). Following local and then national media reports in April (described in Chapter 9), which suggested that the police were looking at the deaths of other patients, the GMC telephoned and then wrote to the police on 11 April 2001 (GMC100917, p538). In that letter, the case worker said that the GMC had been granted additional powers by Parliament the previous summer which, in effect, allowed it to consider restricting a doctor's registration status, without prejudice, at any stage of its proceedings if it was deemed to be in the public interest or in the interests of the doctor concerned. All meetings of a new Interim Orders Committee (IOC) were to be held in private.

6.8 The GMC letter stated: *"It appears that, given the nature of the allegations against Dr Barton, this case may fall into the above category"* (GMC100917, p538).

6.9 The IOC was established in August 2000 as a direct result of the public concern caused by the GMC's inability to act in the case of Harold Shipman, despite the fact that he had been arrested on a charge of murder. A case had to be considered by a Medical Screener before it could be referred to the IOC.

6.10 The IOC (subsequently the Interim Orders Panel) had the task of deciding whether it was necessary to suspend a doctor's registration or to impose conditions on a doctor's registration, pending a final decision in the case. Interim orders are imposed if it is necessary to protect the public, or is in the public interest or in the doctor's interest. Such orders can be imposed for a maximum of 18 months, after which time they must be reviewed in the High Court.

6.11 In the same letter of 11 April 2001, the GMC said it needed sufficient information to consider if an interim order was appropriate and asked the police to provide *"a brief case summary, copies of witness statements, transcripts of interviews conducted, copies of the medical expert's report and the relevant medical notes".* The GMC acknowledged that in the handling of confidential information the police needed to *"balance the rights of privacy of the individual against a necessary need to protect the public"* (GMC100917, p538).

6.12 The GMC pursued its request in a meeting between its solicitors and the Hampshire Constabulary and in a further letter of 4 May 2001 (GMC100917, p545). On 6 June, the police provided the GMC with the clinical notes of Mrs Richards and statements from two members of her family (p554). The police did not provide the GMC with Professor Brian Livesley's report (see Chapter 5).

6.13 The GMC began to investigate Dr Barton as soon as it received this information. On 13 June, Gerry Leighton, Assistant Registrar, wrote to Dr Barton inviting her to appear before the IOC on 21 June. The letter suggested that the information received from Hampshire Constabulary was *"of such a nature that it may be both in the public interest and in your own interest that your registration to be restricted whilst those matters are resolved"* (GMC100917, p606).

6.14 Dr Barton attended the Committee hearing on 21 June. It was the GMC's submission that Dr Barton's registration should be suspended on an interim basis (GMC101057, p60).

6.15 The legal assessor[1] asked GMC Counsel whether the police had obtained *"independent medical evidence to determine whether their case can be substantiated"*. GMC Counsel said she was only aware of the material sent by the police, all of which had been put before the IOC (GMC101057, p61).

6.16 Dr Barton's representative had more information because the same firm of solicitors was instructed in the criminal proceedings. He was able to tell the IOC that independent expert opinion had been sought by the police, but he did not know what that report said (GMC101057, p61). He made the submission that *"this case may have been brought here prematurely"* before an expert report had been provided (GMC101057, p62).

6.17 Dr Barton's solicitor submitted that, on the evidence provided, *"there is no conceivable basis here for suggesting that the drugs that were prescribed and administered to this lady were inappropriate"* (GMC101057, p61).

6.18 As noted in paragraph 6.12, Professor Livesley's report had not been disclosed to the GMC by the Hampshire Constabulary. It was not available to any party during the hearing. That report had concluded:

> "… death occurred earlier that it would have done from natural causes and was the result of the continuous administration of diamorphine, haloperidol, midazolam and hyoscine which had been prescribed to be administered continuously by a syringe driver for an undetermined number of days." (GMC100096, p163)

6.19 The legal assessor reminded the IOC that an order could only be imposed if it was *"necessary for protection of the members of the public, or otherwise in the public interest, or in the interests of the practitioner"*. He went on to say: *"in this particular case, I simply draw your attention to the absence of any independent specialist medical expert opinion indicating fault of any kind on the part of Dr Barton"* (GMC101057, p65).

6.20 The IOC considered the case in private before calling all parties back into the hearing room. The Chair announced:

> "Dr Barton, the Committee have carefully considered all the evidence before it today. The Committee have determined that they are not satisfied it is necessary for the protection of members of the public, in the public interest or in your own interests that an order under Section 41(A) of the Medical Act 1983 should be made in relation to your registration." (GMC101057, p66)

1 Legal assessors are experienced barristers or solicitors appointed to advise the tribunal on questions of law as to evidence or procedure. The legal assessor provides advice to the tribunal, including when it is deliberating in private, but takes no part in the decision-making process.

The documents show that, in accordance with normal practice, no reasons were given because an order was not made.

6.21 On 21 June, a note from the Department of Health's South East Regional Office to its Ministerial Private Office provided an update on Dr Barton's case. The GMC had indicated that it *"was aware that asking IOC to consider the case, while the CPS was considering the police report, carried some risk but was of the view that an early reference was required. The GMC will obtain the appropriate expert report and liaise further with the police"* (GMC100891, p141).

The GMC investigation: second Interim Orders Committee

6.22 On 14 August 2001, Detective Superintendent (Det Supt) Jonathon (John) James wrote to the GMC to inform it that the CPS had decided there was insufficient evidence to prosecute Dr Barton in relation to Mrs Richards, but further complaints had been made by relatives of other patients and the police needed to investigate these (GMC100829, p534).

6.23 On 6 February 2002, Det Supt James wrote to the GMC explaining that the cases of four other patients (Eva Page, Alice Wilkie, Arthur Cunningham and Robert Wilson), as well as Mrs Richards, had been considered and that no further police investigation was required (GMC101057, p1111). The police provided the GMC with documents which included three expert reports, from Professor Livesley, Professor Gary Ford and Dr Keith Mundy (GMC100917, p630). Professor Ford's report, dated 12 December 2001, stated that the cases (of Mrs Page, Mrs Wilkie, Mr Cunningham, Mr Wilson and Mrs Richards) raised serious concerns that Dr Barton's level of skills were not adequate at the time the patients were admitted. His conclusions were:

> "7.2 … having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the GMC or UKCC." (GMC101057, p1189)
>
> "7.3 My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease, lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of older people with rehabilitation needs." (p1189)
>
> "7.4 … Opiate and sedative drugs used were frequently used at excessive doses and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people." (p1189)
>
> "7.5 … There is a possibility that prescriptions of subcutaneous infusions of diamorphine, midazolam and hyoscine may have been routinely written up for many older frail patients admitted to Daedalus and Dryad wards, which nurse then had the discretion to commence. This practice if present was highly inappropriate, hazardous

> to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of 'involuntary euthanasia' existed on the ward." (p1190)
>
> "7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Dr Barton, were not adequate at the time these patients were admitted." (p1190)

6.24 On 12 February, the GMC asked Dr Malcolm Lewis, the same Medical Screener who had reviewed the case of Mrs Richards, if the case warranted a referral back to the IOC. This was while they were waiting for the full documentation from the police, but summaries of the expert reports had been provided. Dr Lewis was told that if he needed the full reports, he should ask; the police told the GMC on 14 February that the reports would be provided (GMC101058, pp6–8).

6.25 Dr Lewis noted: *"Professor Ford's analysis of the detail of this case raises sufficient grounds to refer to IOC."* He completed the screening decision form in February 2002 (GMC100917, pp516–22).

6.26 On 21 March, Dr Barton appeared before the IOC for the second time (GMC101057, pp16–39). Three of the Committee members were the same, including the Chair (GMC100112, p22).

6.27 Mr Lloyd, Counsel for the GMC, explained the history of the GMC investigation and the local restrictions that were in place. This was a reference to the voluntary restriction on prescribing opioids in Dr Barton's GP practice, to which she had agreed in February 2002 (DOH800093). He submitted 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 and it may be that the Committee would wish to consider imposing a condition that restricts her to NHS practice"* (GMC101057, p20).

6.28 The weakness in local restrictions is evident. Without a restriction on her licence to practise, Dr Barton could move to any other Trust and work in a hospital again. Similarly, any potential employer would not automatically find details of this situation when they checked Dr Barton's registration with the GMC, if there was no restriction on her licence. There was no guarantee that the local restrictions would continue after this hearing and, as a matter of fact, they did not continue.

6.29 Dr Barton gave evidence at this hearing (GMC101057, p21). She explained that the time pressures at the hospital meant that she had to choose between writing notes for each patient or seeing the patients. She said: *"I chose to see the patients, so my note-keeping was sparse"* (GMC101057, p26).

6.30 Dr Barton said that, in addition to her practice as a GP and her heavy workload at the hospital, she was the Chair of the local Primary Care Group, which meant she knew *"only too well that the health care trust could not afford to put any more medical input than I was giving them"*. Dr Barton said that after she resigned, her role was taken by a full-time staff-grade doctor and she understood that by the time of this hearing a request had been made that two full-time staff-grade doctors were needed (GMC101057, p25).

6.31 The documents are significant in assessing what weight should be given to Dr Barton's workload. The Panel has seen nothing in the documents to indicate that she raised concerns about her workload until she was in the process of being investigated. Dr Barton herself noted that she did raise her concerns about the levels of nursing and medical staff in writing, but not until 2000 (GMC101057, p35). This was after the police investigation had begun (GMC101012, p16; GMC101058, p27).

6.32 The defence produced evidence during the hearing which it had not presented to the GMC in advance. This included Dr Barton's letter of resignation and other correspondence relating to the pressures on Queen Alexandra Hospital and changes in the admissions at Gosport War Memorial Hospital. The Chair said: *"I assume they have been circulated."* There was no response, even though in this case the documents had not been circulated in advance (GMC101057, p32).

6.33 Counsel for the GMC was asked if he wished to ask questions of Dr Barton. No questions were asked. The documents show that the opportunity to explore the expert reports from Professor Ford, Dr Mundy and Professor Livesley was missed. This is surprising given the very serious expert concerns about Dr Barton's prescribing. Nor was there any challenge to the newly introduced material about pressures of work. The Panel also finds this surprising.

6.34 Defence Counsel submitted that there was no evidence that the experts were aware of the limited hours worked by Dr Barton (GMC101057, p37).

6.35 One of the IOC members, Gareth Wardell, asked Dr Barton:

> "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 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? Dr Barton said that she did not think that this was a problem in Gosport at that time." (GMC101057, p34)

6.36 The Panel notes the terms in which this question was put, which were clearly sympathetic to Dr Barton and which appear to prejudge the outcome.

6.37 As the hearing drew to a close, Dr Barton said: *"I am not prescribing any opiates or benzodiazepines at the moment"* (GMC101057, p37). This was a further reference to the voluntary restriction on prescribing opioids in her GP practice to which she had agreed in February 2002 (DOH800093).

6.38 The IOC deliberated in private, then announced that *"on the basis of the information available"*, it had determined that the test was not met and that it was not necessary to make an interim order. The Committee gave no detail of how or why it reached this determination (GMC101057, pp38–9).

The GMC investigation: third Interim Orders Committee and the Preliminary Proceedings Committee

6.39 The local restrictions agreed in February 2002 were due to be reconsidered in light of the findings of the IOC hearing.

6.40 Dr Barton's solicitors wrote to Dr Peter Old, Director of Public Health for Portsmouth and South East Hampshire, on 26 March 2002 asking the Health Authority to reconsider the voluntary restriction in light of the decision of the IOC (DOH603360). The documents show that Dr Old replied on 28 March (DOH603361). However, the Panel has not seen Dr Old's response. On 2 April, Dr Barton's solicitors wrote to Dr Old, saying Dr Barton was *"content voluntary prescribing restriction is lifted but restriction on medical care at GWMH should continue and be reviewed monthly"* (DOH701884, p2; DOH702154).

6.41 The voluntary prescribing restriction was then lifted in April 2002 but the GMC was not notified that the local restriction had been varied in this way (DOH603360; DOH702154; GMC101057, p797; DOH701884, p2).

6.42 On 11 July, the GMC wrote to Dr Barton, informing her *"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"* (GMC101057, pp777–80). The information related to allegations of inappropriate prescribing and management in relation to Mrs Page, Mrs Wilkie, Mr Cunningham, Mr Wilson and Mrs Richards. The information had been considered by a Medical Screener and had been referred to the GMC's Preliminary Proceedings Committee (PPC). The available documents suggest that the GMC notified the Hampshire and Isle of Wight Strategic Health Authority on 5 August (DOH701884, p2).

6.43 On 27 August, the Primary Care Trust (PCT) met and decided that no local action needed to be taken against Dr Barton (DOH701884, p2). The available documents suggest that the PCT's rationale was that suspension was not justified because the GMC had decided to take no action in March 2002. There were continuing concerns in relation to her role as a clinical assistant at the hospital, where she no longer worked, but not in relation to her role as a GP. The suspension of a senior GP would be a strain on resources. The PCT discussed 'lines to take' relating to different possible outcomes of the forthcoming PPC (DOH701884, p2).

6.44 The Trust did not tell the GMC of this meeting, nor of the reasons for its decision.

6.45 On 29 August, the PPC considered the papers provided by the GMC and a letter from Dr Barton's solicitors, setting out her response to the allegations (GMC101057, pp774–6, pp1507–15).

6.46 The PPC decided that *"the matter unequivocally needs to be tested by the Professional Conduct Committee"* (GMC100941, pp416–19). The PPC did not refer Dr Barton back to an Interim Orders Committee. On 12 September, the GMC decided that, because the status of the case had changed and it had been referred to the PCC, a further application should be made for an interim order (GMC100941, p469).

6.47 The PPC's determination also referred to a Dr Althea Lord, consultant geriatrician at the hospital:

> "The Committee noted that Dr Barton's post was supervised by a consultant, Dr Lord, who must therefore assume some responsibility for the events … 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." (GMC000187, p2)

6.48 The Panel has seen no documentation to suggest that the GMC did re-screen Dr Lord or otherwise follow up on this part of its determination.

6.49 The GMC became aware of the Commission for Health Improvement (CHI) report, which had been published in July 2002, and attended the CHI offices where it examined files it considered to be of use. The GMC wrote to the Trust to ask for information about the complaints listed in the report (GMC101057, p985). The GMC's letter, of 21 August 2002, was addressed to Dr Richard Ian Reid, the Medical Director, one of the consultants who was responsible for monitoring and supervising care on the wards.

6.50 In a further development, on 12 September, Sir Liam Donaldson, the Chief Medical Officer, sent an email to the Trust, saying that he thought the *"ban on prescribing opiates should be re-instated immediately"* (DOH701884, p3).

6.51 On 13 September, the Trust held a meeting with Dr Barton. It was agreed that a review of the prescribing restriction would take place when she returned to work from sick leave (DOH701884, p3).

6.52 The GMC was not told of this intervention by the Chief Medical Officer at this time nor of the meeting between the Trust and Dr Barton.

6.53 On the morning of 19 September, before the third IOC hearing that day, Dr Simon Tanner, Director of Public Health, Hampshire and Isle of Wight Strategic Health Authority, spoke to the GMC. He told them about the 1991 nurses' dossier that had been provided (see Chapter 4). During that call, Dr Tanner told the GMC that the Chief Medical Officer had indicated that his view was that voluntary restrictions on prescribing should be reinstated. Dr Tanner said Dr Barton was currently on sick leave. He told the GMC that the voluntary undertaking had ceased following the last decision of the IOC to make no order.

6.54 The documents suggest that this was the first time the GMC was made aware that the voluntary undertaking had not continued in the intervening period (GMC100088, pp77–8).

6.55 On 19 September, Dr Barton appeared before the IOC for the third time (GMC101057, pp781–99; GMC100112, p22).

6.56 The IOC was not informed that a telephone call had been received from the Trust before the hearing, stating there was no local voluntary restriction in place on prescribing.

6.57 Counsel for the GMC argued that the relevant change in circumstances was that the CPS was reconsidering the original decision not to pursue criminal charges. However, she said she was sure that Dr Barton's solicitor:

> "… 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."

Counsel for the GMC then added: *"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"* (GMC101057, p795).

6.58 The Panel has found no documents showing that any such pressure was applied to the CPS.

6.59 The solicitor for Dr Barton made submissions that his colleague (who was present at the hearing) had spoken to Detective Chief Superintendent (Det Ch Supt) Steven Watts and he summarised an attendance note of a telephone conversation between them (the note was not provided):

> "The understanding that [his colleague] 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." (GMC101057, p796)

6.60 The Panel has found that on the day of the IOC hearing Det Ch Supt Watts telephoned the CPS to inform it of a major development in the form of the receipt of papers referred to as the nurses' dossier, that the Trust had appointed two senior officials to investigate these matters, and that the police were taking steps to establish the provenance of the papers and why they had not come to their attention before now (CPS000932). The GMC had not been given this information by the police and the IOC hearing proceeded without this knowledge. Counsel for the GMC made no representations about the submission which had been made by Dr Barton's solicitor and did not ask for time to confirm its accuracy.

6.61 The legal assessor invited Dr Barton's solicitor to make comments about *"the propriety – not the power, but the propriety"* of the IOC considering the case again *"without any fresh evidence at all"* (GMC101057, p796).

6.62 Dr Barton's solicitor said that Dr Barton *"does not routinely prescribe benzodiazepines or opiates"*. He made submissions that the only real change was that the condition she had made with the Health Authority not to prescribe opioids or benzodiazepines had lapsed at the end of March *"and the Health Authority did not see fit to invite her to renew that undertaking"* (GMC101057, p797).

6.63 The legal assessor advised the IOC *"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"*. The IOC's determination was *"there is no new material in this case since the previous hearing of the Interim Orders Committee"*. No order was made (GMC101057, pp798–9).

The GMC investigation: fourth Interim Orders Committee

6.64 Dr Barton returned to work as a GP. In accordance with the understanding reached while she was on sick leave, the issue of prescribing was reviewed. On 9 October 2002, Dr Barton attended a meeting with representatives of Fareham and Gosport PCT including Alan Pickering, Acting Chief Executive. The note of that meeting refers to an offer by Dr Barton of a ban on her prescribing opioids. This was agreed with the Trust. Benzodiazepines would be prescribed in accordance with British National Formulary (BNF) guidance. Dr Barton had been advised by her medical defence society to carry a single vial of diamorphine *"in case she was presented with an absolute medical emergency"* (GMC100943, p532). The Trust appointed a pharmaceutical adviser to examine Dr Barton's prescribing data. The Trust held meetings which confirmed that she was complying with the voluntary restriction (GMC101057, p13).

6.65 The GMC was not informed of the agreement reached in October 2002.

6.66 Also in October 2002, the GMC considered the impact on its processes of the police referral to the CPS and the nurses' dossier, which contained details of the concerns that had been raised in 1991. On 3 October, the GMC had a meeting with its solicitors, Field Fisher Waterhouse (FFW), where it was agreed that the speed of the GMC investigation would be affected by the police investigation and any prosecution by the CPS (GMC100942, p614). At this stage it was discussed whether the police could be asked to provide the papers on the understanding that no action would be taken until the conclusion of the investigation or prosecution. The advantage would be that the GMC would be able to prepare the case and be ready to start the regulatory proceedings as soon as possible. As for the impact of the nurses' dossier, the GMC took advice and decided there was insufficient material to go back to the IOC (GMC101302, pp212–13).

6.67 On 3 October, the GMC considered which expert to instruct. Matthew Lohn, a solicitor and partner at FFW, considered whether to use Professor Ford, Dr Mundy or Professor Livesley, or another expert *"with more relevant experience, eg, in cottage hospital".* It was noted that using another expert carried the *"danger of undermining earlier reports"* and that it would be better to ask Professor Ford to review his reports, *"in light of all info, eg, [Dr] Barton's responses re: nature of hospital, staffing etc"* (GMC100089, p25).

6.68 Before FFW could arrange this with Professor Ford, the GMC agreed to put its investigation on hold to await the outcome of Operation Rochester (GMC100090, p1). It would be another year before action was taken leading to the fourth IOC.

6.69 Following a meeting on 30 September 2003, Hampshire Constabulary wrote to the GMC on 6 October. The letter records that, of 62 cases examined, *"in a significant number of those cases, the experts took the view that there was negligent care and that the causation of death is unclear"* (GMC100090, p42). The police had concluded that they needed to make a further assessment and interview Dr Barton. That interview was likely to take place in January 2004 (p41). In considering whether they should disclose information to the GMC for the purposes of the GMC's processes, the police had to consider the risk to the public. Their understanding was that Dr Barton was not allowed to work at the hospital and *"is not authorised to prescribe opiates"*. Disclosure by the GMC to Dr Barton would undermine the police strategy for their interview with her (pp42–3).

6.70 On 6 November 2003, a Medical Screener sent a note to the GMC advising that Dr Barton should not be sent back to the IOC. Among the reasons given was *"she has voluntarily agreed to restrict her prescribing of certain drugs"* (GMC100090, p46). This information came from the letter from the police. The GMC had not sought verification of the terms of the voluntary restriction.

6.71 On 4 December, the GMC had internal discussions when it was realised that there had been no attempt to liaise with Dr Barton's employers to see whether the employers needed to consider suspending her (GMC100090, p50).

6.72 On 9 February 2004, Mr Pickering wrote to the GMC in response to an enquiry about the local restrictions (GMC100090, p77). He said there was an agreement that Dr Barton would not admit patients to the hospital, nor would she supervise them. Despite having been at the meeting where it had been agreed, Mr Pickering did not tell the GMC there had been a revised prescribing condition in place since 9 October 2002.

6.73 As a result of this letter, the GMC was under the mistaken impression that Dr Barton was not subject to a voluntary prescribing undertaking and wrote to the police informing them of this (incorrect) understanding (GMC100090, pp88, 92).

6.74 In understanding the relevant chronology, the Panel notes that the police but not the GMC had been given a copy of Professor Richard Baker's report (see Chapters 4 and 5). In December 2003, in response to the GMC, the police confirmed that they did have a copy but that it had been provided on a confidential basis (GMC100090, p49). The GMC did not receive a copy until 17 May 2004 and then only on terms which restricted disclosure (GMC101057, p734).

6.75 On 24 June 2004, Finlay Scott, GMC Chief Executive, telephoned Paul Kernaghan, Hampshire Constabulary's Chief Constable, to discuss the GMC's concerns about the delay in progress. During this call, Mr Scott (incorrectly) indicated that the prescribing undertaking had lapsed. The Chief Constable *"echoed the concerns of the GMC"* and said he would speak to the officer in charge of the case upon his return from annual leave (GMC101057, p435).

6.76 On 2 July, the Chief Constable wrote to Mr Scott updating him on the investigation. He said he had met with Mr Pickering on 11 June who had told him that there was a voluntary arrangement with Dr Barton *"that her prescription of Opiates and Benzodiazepines are supervised at the time by another GP"* and that her prescription levels were being monitored independently through the Trust IT systems (GMC101247, pp105–6). The Panel notes that this was not an accurate description of the voluntary restriction which in fact provided that Dr Barton would not prescribe opioids at all and that benzodiazepines could be prescribed in line with the BNF guidance.

6.77 On 21 July, Detective Superintendent (Det Supt) David Williams informed the GMC that the Category 2 cases (see Chapter 5) would be disclosed to the GMC that week *"in the absence of strong legal rationale"*. He went on to say: *"I confirm that the following information has been received from the local healthcare trust … Dr Barton has undertaken not to prescribe benzodiazepines or opiate analgesics from 1 October 2002"* (GMC101057, p430). This was again an incorrect description of the restriction.

6.78 The GMC chased up the promised disclosure of the Category 2 cases on 5 August. It expressed its concerns about patient safety and felt that an interim order was more likely to be obtained with the new material (GMC101057, p510).

6.79 The police replied that a meeting with lawyers had been arranged for 12 August. Det Supt Williams said:

> "… 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 independently assessing on going risk." (GMC101057, pp509–10)

Following the incomplete information in the letter of 9 February from Mr Pickering, the GMC had not sought a formal report or statement from the Trust detailing the conditions.

6.80 On 10 September, the GMC received documents from the police in relation to 19 Category 2 cases. On 17 September, the GMC informed the police that it had examined the disclosed material and intended to seek a referral to the IOC (GMC100091, pp138–9; GMC101057, p948).

6.81 On 30 September, Det Ch Supt Watts provided a statement to the GMC, summarising the investigation into Dr Barton (GMC101057, pp835–44). This statement was provided for use at the IOC hearing.

6.82 On 24 September, the GMC wrote to Dr Barton informing her that the new information from the police would be put before the IOC on 7 October (GMC101057, pp43–4).

6.83 On 1 October, the GMC sent instructions to Roger Henderson QC to represent it at the IOC. The instructions were to seek an interim order of suspension and, if this was unsuccessful, to ask the IOC to consider the option that Dr Barton should not prescribe benzodiazepines or opioids at all (GMC101302, pp1644–50).

6.84 On 5 October, Mr Henderson responded, saying *"in the absence of any recent problems or report problems with her practice and the fact that the present evidence advances the case only a little"*, he wondered if the GMC should seek the proposed restriction on prescribing benzodiazepines and opioids rather than suspension (GMC101302, pp1639–40). The GMC agreed with his advice and this was the submission made at the fourth IOC hearing.

6.85 On 7 October, Dr Barton appeared before the IOC for the fourth time (GMC101057, pp72–110; GMC100112, p22).

6.86 Solicitors for Dr Barton provided the GMC with a copy of the agreement reached in October 2002 that Dr Barton would not prescribe opioids and that benzodiazepines would only be prescribed in line with BNF guidance. This was the first time that the GMC had understood the correct details of the voluntary restriction. For two years the GMC had believed, first, that the prescribing restriction had lapsed (even after it had been reinstated) and then, from police reports, that it was different to the one which actually was in place.

6.87 The IOC decided it was not necessary to impose an interim order on Dr Barton's licence to practise and gave the following reasons: the police investigation was not finished and Dr Barton had neither been arrested nor charged. The IOC noted there had been no concerns about Dr Barton's work in general practice and that there was a voluntary undertaking in place. The IOC did not explain why it rejected Mr Henderson's submission that an interim order was

necessary, in addition to the voluntary undertaking, because a voluntary undertaking was not available to members of the public or prospective employers and was *"of no particular duration and capable of being withdrawn at any time and incapable of enforcement by the General Medical Council"* (GMC101057, p74).

The GMC investigation: fifth Interim Orders Committee

6.88 The Panel notes that, while awaiting the conclusion of the police investigation, the GMC corresponded with the Trust. On 8 October 2004, the GMC wrote to the Chief Executive of the Trust to ask for full details of the terms, start and expiry, and monitoring of any voluntary agreement with Dr Barton restricting her prescribing of opioids and benzodiazepines (GMC100914, p160). On 12 November, Mr Pickering, by then Interim Chief Executive of Fareham and Gosport PCT replied, again providing incorrect information. He told the GMC that Dr Barton had *"agreed to a voluntary arrangement from 1st October 2002 that she would not prescribe benzodiazepines or opiate analgesics"* (GMC101066, p751).

6.89 On 25 November, Hazel Bagshaw, Pharmaceutical Adviser, Fareham and Gosport PCT, wrote the first of a series of letters to the GMC, providing full details of Dr Barton's prescribing data from October 2002 to August 2004 (GMC100135, p383). This letter did not set out the exact terms of the prescribing restriction.

6.90 More than two years later, on 22 December 2006, the GMC understood that full disclosure from the police was imminent. Eversheds, the solicitors instructed by the GMC at this time, advised that the GMC should await disclosure of the full expert reports which they had requested from the police as it could be seen from the summaries that they were *"critical of care afforded to patients and will almost certainly form the basis of a strong case of serious professional misconduct. Clearly the GMC will wish to review the IOP [Interim Orders Panel] position in this case"* (GMC101066, pp644–5). As a result of changes to the law in 2004, Medical Screeners had been replaced by Case Examiners and the IOC had become the Interim Orders Panel (IOP).

6.91 Paul Hylton of the GMC responded on the same day, saying:

> "My fear has always been that we would have too little information in respect of Dr Barton and too much information in respect of doctors who are not yet referred. Once all the information is in and you have had a chance to analyse it we will be in a position to decide whether Dr Barton, or any other doctor, should be referred to IOP." (GMC101066, p644)

6.92 By 13 March 2007, having repeatedly requested the information, the GMC received disclosure from the police in relation to all the cases. Ann Reeves wrote to the GMC and asked how it was that Dr Barton was still practising (GMC101066, p688).

6.93 Eversheds told the GMC that it was working through the evidence for the most serious cases to refine the preliminary advice which had already been given. It was expected that this review would be completed within two or three weeks and that there would be a referral to the IOP *"in due course as there is now a much larger body of evidence available"* (GMC101066, pp687–8).

6.94 Mr Hylton replied: *"if we are of the view that the matter should be referred to the case examiners for consideration of a referral to the IOP then we shall do so expeditiously."* He commented:

> "… there seems to be an attempt to steer our investigation by the relatives or to move it forward at a pace that the relatives believe it should travel at. I am happy that Eversheds proceed at a pace and in the direction that your experience tells you you should go at this evidence evaluation stage. We cannot afford to get the investigation wrong or to allow the GMC to be used by families as a way of getting at Dr Barton." (GMC101066, p687)

6.95 In the event, the GMC did not take the case of Dr Barton to a fifth IOP until July 2008 – 16 months after this exchange.

6.96 In May 2007, the GMC transferred instructions from Eversheds back to FFW. The documents do not disclose the reasons for this change.

6.97 At a telephone conference between all parties on 6 September 2007, a fitness to practise hearing was provisionally listed to take place between 8 September 2008 and 31 October 2008 (GMC100903, pp352–3). The time estimate was 40 days.

6.98 On 28 April 2008, David Horsley, the Coroner for Portsmouth and South East Hampshire, informed the GMC that simultaneous inquests would be held into ten deaths at Gosport War Memorial Hospital, and that it was unlikely these would be heard earlier than the autumn of 2008 (GMC100947, pp352–3).

6.99 On 18 June, the GMC and Dr Barton's solicitors agreed that it was inappropriate for the fitness to practise hearing to take place before the inquests (GMC100903, p160). The provisional listing was set aside.

6.100 On 30 June, the GMC wrote to Dr Barton to tell her that the Case Examiners had decided that her case should be considered by the IOP. This letter indicated that the fitness to practise hearing had been put back and, in the meantime, Dr Barton was able to practise without restriction. It set out the reasons for the Case Examiners' decision and said that, since the last IOC hearing, *"the number of cases to be considered by the FtP [Fitness to Practise Panel] is now much larger and the concerns about this doctor much greater"* (GMC100947, p374).

6.101 On 11 July, Dr Barton appeared before the IOC (now the IOP) for the fifth time (GMC100947, pp384–414).

6.102 Mr Stephen Brassington, Counsel for the GMC, submitted that *"Dr Barton appears, at some stage in 2002, to have entered into a voluntary arrangement with her Primary Care Trust that she not [sic] prescribe opiates or benzodiazepines"* (GMC100947, p399). In response to a question by the IOP he submitted: *"conditions should mirror those which the doctor previously gave as undertakings"* (GMC100947, p401).

6.103 Shortly before making that submission, Mr Brassington had been asked by the IOP *"are you aware of the current status of those undertakings with the hospital?"*, to which he replied, *"No"* (GMC100947, p400). Dr Barton's solicitor indicated he would be able to assist and later did.

6.104 Mr Brassington referred the IOP to the statement of Det Ch Supt Watts dated 30 September 2004. This said, incorrectly: *"Dr Barton has undertaken not to prescribe benzodiazepines or opiate analgesics"* (GMC100947, p169).

6.105 The Panel notes that at no time did Counsel for the GMC provide the information that the GMC had had in its possession since the fourth IOC hearing; namely, that in October 2002 Dr Barton had reached an agreement with the Trust that she would not prescribe opioids and only prescribe benzodiazepines in line with BNF guidance. The GMC could have sought an accurate and up-to-date statement from the Trust but did not do so.

6.106 During the hearing, Dr Barton's solicitor handed the IOP a copy of the letter dated 9 July 2008 from Hazel Bagshaw (now Community Pharmacy Development Manager at the PCT) to the IOP (GMC100947, p383). The solicitor confirmed that the GMC had not been given a copy in advance and he had not provided a copy that morning to GMC Counsel (GMC100947, p406). This letter said the agreement was: *"Any prescriptions for diazepam issued will be in line with BNF guidance with no prescribing of diamorphine"* (GMC100947, p383).

6.107 Dr Barton's solicitor made the following submission:

> "As this Panel will be aware, in relation to opioid analgesics they technically include a large number of medications; for example, that term of itself would embrace codeine. It has never been part of the voluntary arrangement that Dr Barton was not allowed to prescribe some opioid analgesics … the understanding is and the practice is that Dr Barton does not prescribe … schedule 2 drugs, the drugs of the category such as morphine … pethidine and so on. I want to make that clear to the Panel that it is not absolutely technically what the words might be taken to mean on the face of them." (GMC100947, p406)

6.108 For the first time, an interim order was imposed, placing conditions on Dr Barton's registration (GMC100947, pp410–11). Condition 5 said: *"You must not prescribe diamorphine and you must restrict your prescribing of diazepam in line with BNF guidance."* Among the reasons for its decision, the IOP said that while it noted Dr Barton's compliance with the local restriction, *"it is concerned that the agreement is voluntary and there are no formal arrangements in place to monitor your continued compliance"* (GMC100947, p413).

6.109 The documents show that the GMC pursued concerns about Dr Barton's prescribing through five interim orders proceedings. An order was made on the fifth occasion. The Panel notes that the reason given – the fact that the agreement was voluntary – had applied from 2002 when the agreement was first made. As a voluntary agreement, it could lapse or be lifted without the GMC becoming aware. The interim order actually recognising these weaknesses did not come into effect until eight years after the GMC was made aware of the concerns in 2000.

6.110 The Panel also notes that the GMC was not clear about the terms of the voluntary agreement. Even in July 2008, as the interim order was being considered, its Counsel was misquoting the agreement despite the fact that a copy had been provided at the time of the previous IOC in October 2004. Given the importance of the issues, it is surprising to find that there was confusion on this key element of the argument.

GMC investigation halted

6.111 Prior to Operation Rochester, the GMC had anticipated a fitness to practise hearing in April 2003. On 2 December 2002, Hampshire Constabulary wrote to the GMC's solicitors *"to formally ask you to consider pending the anticipated hearing in April until further notice"*

(GMC101057, p446). Three weeks later, the solicitors replied: *"I have received formal instructions from the GMC to confirm that the GMC proceedings regarding Dr Barton's fitness to practise will be stayed pending the conclusion of the police enquiry"* (p448).

6.112 By accepting the police's request, the GMC's investigation effectively stalled. As a result, the hearing which had been set for April 2003 did not take place until June 2009. By the time of the sanctions hearing there had been a ten-year delay which in itself affected the sanction which was imposed. The Panel notes this as one of a number of examples of a process of accountability being undermined by deferring to another organisation.

The GMC investigation: fitness to practise

6.113 On 18 January 2007, Hampshire Constabulary provided the first tranche of material arising from Operation Rochester (GMC100105, pp510–12). The GMC immediately began to work through it to prepare for the fitness to practise hearing. As noted above, the Coroner gave notice that simultaneous inquests would be heard into ten deaths at the hospital. These were the ten cases the police had categorised as *"most serious"* (GMC100947, pp352–3). The question then arose as to whether the fitness to practise proceedings could continue before the inquests were completed.

6.114 On 3 June 2008, Tom Kark, a barrister, advised the GMC that although there was no legal bar to the GMC hearing and the Coroner's inquest taking place simultaneously, *"serious practical and tactical problems … would arise"*. He said there was no *"legal bar"* that one set of proceedings should take precedence over the other, but it was his advice that the *"preferred course would undoubtedly be for the Coroner's Inquest to take place first and the GMC case to follow"*. He set out the reasons for this in his advice (GMC100110, pp17–18).

6.115 On 18 June, all parties agreed to set aside the 8 September 2008 listing date (GMC100903, pp158–9). The fitness to practise hearing was re-listed to take place from 8 June 2009 to 21 August 2009 (GMC100987, p8).

6.116 The inquest into the death of Mrs Richards was not joined to the other ten deaths, so the question arose as to whether the fitness to practise hearing could proceed in her case. Gillian Mackenzie asked the GMC not to hold the fitness to practise hearing in relation to her mother until after the inquest. The GMC refused. Mrs Mackenzie said in those circumstances she was not willing to give evidence at the fitness to practise hearing and did not do so (BLC003383). The hearing began on 8 June 2009. The inquest into the death of Mrs Richards would not be held until 2013.

6.117 On 8 June 2009, the fitness to practise hearing began in London (GMC100603, p5). The hearing was held in public and the families of the 12 patients (see paragraph 6.122) attended throughout. The panel Chair was Andrew Reid, LLB JP. The panel members were Joy Julien, Pamela Mansell, William Payne and Dr Roger Smith. The legal assessor was Francis Chamberlain.

6.118 The GMC was represented by FFW solicitors and two barristers (also referred to as Counsel), Mr Kark and Ben Fitzgerald.

6.119 Dr Barton was represented by solicitors from the Medical Defence Union and two barristers (also referred to as Counsel), Timothy Langdale QC and Alan Jenkins.

6.120 The purpose of the hearing was to determine whether or not the GMC had proved, to the criminal standard of proof (that is, so that the Fitness to Practise Panel was sure), the charges it had brought against Dr Barton (GMC100603, pp13–25).

6.121 Dr Barton's barrister set out all the charges which were admitted by Dr Barton and these were immediately found proved by the panel because there was no dispute (GMC100603, pp26–30).

6.122 The identity of the patients referred to during the fitness to practise hearings were anonymised as follows:

- Patient A – Leslie Pittock
- Patient B – Elsie Lavender
- Patient C – Eva Page
- Patient D – Alice Wilkie
- Patient E – Gladys Richards
- Patient F – Ruby Lake
- Patient G – Arthur Cunningham
- Patient H – Robert Wilson
- Patient I – Enid Spurgin
- Patient J – Geoffrey Packman
- Patient K – Elsie Devine
- Patient L – Jean Stevens

6.123 The available documents show why it had been decided not to proceed with three further possible cases – Helena Service, Sheila Gregory and one other – despite the fact that the police had identified them as among the ten most serious cases (GMC101181, pp85–9; GMC101068, pp234, 249, 776; GMC100099, pp51–2; GMC100903, pp168–9; GMC100185, pp60–1).

6.124 The GMC presented its case first. It sought to ensure that all the evidence called concentrated on each allegation, which the GMC had to prove.

6.125 The GMC presented its case patient by patient, working through the evidence in relation to each patient, before concluding with the expert evidence of Professor Ford. When writing his expert reports, Professor Ford had seen all the relevant material. In addition, he had had the opportunity to read the transcripts of all witnesses who had given evidence. In the event, the Fitness to Practise Panel accepted his evidence.

6.126 After the conclusion of the GMC case, Dr Barton gave evidence in her own defence and then called a number of witnesses.

6.127 The defence relied upon the expert evidence of Professor Karol Sikora, a cancer specialist with experience of palliative care in that context, but, unlike Professor Ford, not a geriatrician. Professor Sikora had been provided with Dr Barton's statements and the expert reports of Professor Ford but he had not been given the other statements or the patient notes. He had read some of the transcripts of evidence but not all. He was not able to comment on the treatment of any of the 12 patients (GMC100596, p201).

6.128 All the witnesses who gave evidence either swore an oath or affirmed that they would tell the truth. The witness statements and expert reports of witnesses were provided to the Fitness

to Practise Panel. Witnesses were asked whether or not they still stood by what was in their statements; upon saying they did, those statements formed the basis of their evidence and there was no need for the contents to be repeated. Counsel who had called the witnesses then asked further questions (referred to as 'examination in chief').

6.129 Counsel for the opposing side then asked questions in cross-examination. Following this, the barrister who had examined in chief could re-examine the witness about any matters arising from that cross-examination. The Fitness to Practise Panel asked any questions it had. Following this, first the barrister cross-examining and then the barrister examining in chief could ask further questions arising from the answers given to the Fitness to Practise Panel's questions.

6.130 The legal assessor provided legal advice to the Fitness to Practise Panel on a continuing basis. He also provided advice if he felt any errors were being made. For example, following questions from the panel to Dr Reid, the legal assessor gave advice about the sort of questions panel members should ask and the way they should do this.

6.131 During questions from the Fitness to Practise Panel, Mr Payne, a lay panel member, had the following exchange with Dr Reid:

> Mr Payne: "You have said to us that if you would have seen the prescriptions for 20 to 200, that wide range, you would have done something about that."
>
> Dr Reid: "Yes. It was my responsibility to do something about it."
>
> Mr Payne – referring to the only instance before the fitness to practise hearing where Dr Reid had reduced a prescription written by Dr Barton: "When you saw that – and you reduced one from 80 to 40."
>
> Dr Reid: "I did not recollect seeing prescriptions for 20 to 200mg until the police interviewed me and produced a prescription sheet which demonstrated that."
>
> Mr Payne: "With the greatest of respect, doctor, I have difficulty accepting that, because you told me that the sheets are there, you are reviewing the patients, you are on a ward round with people that you say have more experience in this than you and, before you can make a judgment, you must review all the facts." (GMC100605, p302)

6.132 During questions from the panel, the Chair had the following exchange with Dr Reid:

> Chair: "Can you recall a single instance in your year on Dryad Ward where a patient was put on a mix of opiates or syringe driver who did not die?"
>
> Dr Reid: "No, I cannot."
>
> …
>
> Chair: "Before you get to there, somebody in effect has to sign the death warrant, somebody has to prescribe that?"
>
> Dr Reid: "Someone has to make a decision that this patient is for palliation." (GMC100605, p318)

6.133 In re-examination by GMC Counsel, this terminology was explored. The phrase *"death warrant"* had not been used by any of the witnesses. Dr Reid confirmed it was not the sort of expression he would use with relatives, *"Because I think that would be inhumane"* (GMC100605, p335).

6.134 Following the conclusion of Dr Reid's evidence, the legal assessor gave advice *"as to the questioning of witnesses by a Panel"*. He reminded the Fitness to Practise Panel it should *"ask any questions in a fair, impartial and judicial spirit"*. It was inappropriate for a panel member to engage in any form of cross-examination *"which might be interpreted as being intended to support a point of view already held by a panelist"*. He said that this was because panel members should not make up their minds about any of the evidence until they had heard all the evidence. The panel *"must keep an open mind about the evidence until it begins its deliberations and it must make it apparent to all that that is what it is doing".* The legal assessor highlighted the use of the phrase *"I have difficulty accepting that"* as potentially giving the impression that a decision had been reached. Both Counsel were asked if they were content with this legal direction. They were. The Chair thanked the legal assessor for his advice (GMC100605, p358).

6.135 The Fitness to Practise Panel experienced the same difficulties as the police and the Coroner in relation to lack of notes and fading memories, given the amount of time that had passed. In its determination, the panel said:

> "The process has been hampered by the very considerable passage of time since the events in question, the inevitable dimming of memories over that period, the equally inevitable unavailability of some witnesses, and the admitted deficiencies in your own notes, and to some extent those of the nursing staff." (GMC100948, p208)

6.136 The charges faced by Dr Barton included the role of consultants, nurses, other doctors and hospital management in the events at Gosport War Memorial Hospital. However, nobody else faced charges, nobody else was represented, no one had had full disclosure of all the material, and no one had a right to reply to any allegations or aspersions made against them. Any allegations or aspersions were made in the context of a hearing dealing only with Dr Barton.

6.137 The evidence was heard over 37 days. The transcripts are available on the website accompanying the Gosport Independent Panel Report as follows.

Table 4: Witness evidence

Fitness to practise hearing, day no.	Document reference	Page numbers	Witness
2	GMC100603	90–112	Dr Michael Brigg
2	GMC100603	88–90	Linda Wiles
3	GMC100603	116–29	Alan Lavender
3	GMC100603	129–51	Marilyn Jackson
3	GMC100603	153–94	Lesley O'Brien
4	GMC100603	199–205	Diane Mussell
4	GMC100603	239–46	Pauline Robinson
4	GMC100603	205–11	Adele Bindloss
4	GMC100603	212–38	Timothy Coltman

Fitness to practise hearing, day no.	Document reference	Page numbers	Witness
5	GMC100603	252–70	Ann Reeves
5	GMC100603	273–9	Joanna Taylor
5	GMC100603	279–90	Tanya Cranfield
6	GMC100603	295–316	Charles Stewart-Farthing
6	GMC100603	317–19	Pamela Gell
6	GMC100603	319–20	Shirley Sellwood
6	GMC100603	321–43	Gillian Kimbley
6	GMC100603	343–60	Iain Wilson
6	GMC100603	361–4	Neil Wilson
7	GMC100603	370–451	Margaret Couchman
8	GMC100604	7–10	Carl Jewell
8	GMC100604	11–21	Betty Packman
8	GMC100604	21–7	Victoria Packman
8	GMC100604	27–37	Dr Claire Dowse
9	GMC100604	42–5	Ernest Stevens
9	GMC100604	45–7	June Bailey
9–10	GMC100604	47–119, 123–67	Philip Beed
10–11	GMC100604	168–211, 222–64	Lynne Barrett
11	GMC100604	268–98	Dr X
12	GMC100604	302–52	Tina Douglas
12	GMC100604	352–86	Freda Shaw
13	GMC100604	391–474	Shirley Hallman
13	GMC100604	477–85	Sylvia Giffin
13	GMC100604	475–7	Jeanette Florio
14	GMC100605	10–68	Beverley Turnbull
15	GMC100605	74–122	Anita Tubbritt
15	GMC100605	123–45	Dr Victoria Banks
15	GMC100605	146–55	Sharon Ring
15	GMC100605	155–8	Ingrid Lloyd
16	GMC100605	165–89	Daniel Redfern
16–18	GMC100605	189–253, 257–330, 334–58	Dr Richard Reid
18	GMC100605	361–402	Dr Jane Tandy
18	GMC100605	403–8	Dr Rosie Luznat

Fitness to practise hearing, day no.	Document reference	Page numbers	Witness
19	GMC100605	413–57	Dr Arumugam Ravindrane
20–4	GMC100595	9–62, 66–121, 125–201, 207–72, 276–301	Professor Gary Ford
24	GMC100595	301–5	Richard Oliver Samuel
25	GMC100595	309–98	Dr Jane Barton (adjourned, part heard)
26	GMC100667	7–54	Dr Althea Lord
26–30	GMC100667	54–74, 85–107, 111–95, 199–300, 304–59	Dr Jane Barton (adjourned, part heard)
30	GMC100667	359–90	Yvonne Astridge
31	GMC100667	394–416	Dr Jane Barton (adjourned, part heard)
32	GMC100596	7–20	Dr Jane Barton (conclusion)
32	GMC100596	20–66	Isobel Evans
32	GMC100596	68–89	Barbara Robinson
32	GMC100596	89–102	Patricia Wilkins
33	GMC100596	106–49	Sheila Ann Joines
33	GMC100596	149–67	Rear Admiral Michael Atholl Farquharson-Roberts
33	GMC100596	168–78	Dr John Howard Bassett
34	GMC100596	182–240	Professor Karol Sikora
35	GMC100596	255–62	Patrick Carroll
35	GMC100596	262–5	Susan McConnell
35	GMC100596	265–8	Gillian Hughes
35	GMC100596	268–70	Ann Dean
35	GMC100596	271	Angela Southam
35	GMC100596	271–3	Fiona Smart
35	GMC100596	273–9	Dr John Grunstein
36	GMC100596	285–317	Siobhan Collins
36	GMC100596	317–26, 336–43	Gillian Hamblin (read as too unwell to attend)

6.138 On 4 August 2009, Mr Kark made his closing submissions (GMC100596, pp349–408). On 6 August, the legal assessor provided legal advice (GMC101012, pp33–9).

Fitness to Practise Panel determination: Part One, general issues

6.139 The Fitness to Practise Panel retired to decide the case in private. Its determination was set out in three parts. Part One dealt with the general issues that had required consideration during the course of the case (GMC100948, pp209–21). These were as follows:

1. Inappropriate transfers onto Dryad and Daedalus wards
   - The panel heard and accepted evidence that due to *"pressure on bed space"*, patients would be transferred to Dryad and Daedalus wards when their needs were *"beyond the staffing and equipment capabilities"* of those wards. (GMC100948, p209)
   - Dr Reid was among the witnesses who were asked in cross-examination about the tendency of hospitals when sending patients for *"sometimes presenting a slightly rosier picture of the patient's general medical stability".* (GMC100605, p232)
   - Dr Reid explained that this could cause *"Sometimes a very significant problem"* through *"Patients or relatives being told that they were coming to the War Memorial Hospital for rehabilitation when the reality would be that on assessment the chances of rehabilitation were remote"*. (GMC100605, p233)

2. Propensity to sudden deterioration, the effects of transfer and the appropriateness of investigation
   - The Fitness to Practise Panel heard and accepted evidence that many of the patients on Dryad and Daedalus wards *"had a natural propensity toward sudden deterioration and even death, no matter how well cared for"*.
   - It accepted evidence that when patients were subject to transfers it was frequently followed by deterioration in the patient.
   - The panel said that, in addition to early assessment being necessary, it was of the view that further investigations or assessments may have been needed.
   - However, the panel also noted that *"there appeared to be agreement among the experts that when a patient was on the terminal pathway, it would be inappropriate to subject the patient to unnecessary investigation."* (GMC100948, p209)

3. Dr Barton's dealings with patients' relatives
   - Evidence was given by doctors, nurses, consultants and patients' relatives about Dr Barton's interactions with patients' relatives.
   - The panel noted that *"most [witnesses] characterised your approach to relatives as caring and compassionate".*
   - However, it also noted that some relatives described Dr Barton as *"brusque, unfriendly and indifferent".*
   - The panel did not have to make any findings in relation to this as it did not form any part of the charges, but it did conclude: *"your straightforward approach was not appreciated by all relatives"* and *"to some you might at times appear distant or even unfeeling, albeit that this was far from your intention".* (GMC100948, p210)

4. ‘Happy for nurses to confirm death’
   - The panel accepted Professor Ford’s evidence that it was appropriate for staff to delegate the task of confirmation of death to nurses in circumstances where there was *“a natural potential to deteriorate rapidly and without warning”*.
   - The panel also noted that it would have been preferable for there to have been a policy for the ward, rather than a necessity for Dr Barton to include this on individual patients’ notes. (GMC100948, p210)

5. The role of note taking in clinical care
   - The poor note taking by Dr Barton played a large role during the evidence and was the subject of much criticism. (GMC100948, p210)

6. The absence of notes of specific events
   - The Fitness to Practise Panel referred to medical students being frequently taught *“if it isn’t recorded it didn’t happen”* but concluded that: *“as Mr Langdale pointed out in his closing remarks, you are of undisputed good character and that adage cannot be applied to the Panel’s consideration of the facts.”*
   - The panel took the view that the lack of a note was unhelpful but did not automatically mean an event or assessment Dr Barton said had happened had not occurred. (GMC100948, p211)

7. Allegations that Dr Barton did not sufficiently record the drug regime in respect of specific patients
   - The panel said when considering risk, doctors had to consider not only what might happen when the most highly trained and experienced nurses were on duty, but also when the least trained and experienced were on duty. It said: *“patients were entitled to expect that clear written instructions would be available to all those who might be expected to administer the prescription.”*
   - The panel went on to say it did not accept that it was *“safe or prudent”* for Dr Barton to simply tell nurses what she expected the drug regime to be, leaving them to pass it on to each other in verbal handover sessions at shift changes. (GMC100948, pp211–12)

8. Euphemisms relating to end of life status
   - The panel accepted evidence from a number of witnesses that it was usual in the health service to use ‘TLC’ (tender loving care) or ‘make comfortable’ as euphemisms for patients who were to be treated palliatively. (GMC100948, p212)

9. Guidelines and the analgesic ‘ladder’
   - The panel accepted the evidence that the BNF was *“the definitive evidence based guide for doctors on the prescribing of drugs”*.
   - Dr Barton gave evidence that she kept a copy of the Palliative Care Handbook (the Wessex Protocol) in her pocket when on the wards.
   - Both experts agreed the World Health Organization’s analgesic ‘ladder’ emphasises the importance of increasing from weaker to stronger analgesics in steps. The panel said: *“Professor Ford encapsulated this principle as ‘start low, go slow’.”* (GMC100948, p212)

10. Opiates in the treatment of distress, restlessness, agitation and pain

- There was a range of opinion given in evidence as to the appropriateness of using opiates in the control of distress, restlessness and/or agitation in the presence or absence of pain.
- Dr Barton and Professor Sikora, among others, gave their opinion that their euphoric and other properties were helpful.
- Professor Ford did not share this view and *"noted that such a course is neither promoted nor recommended in the palliative literature and guidelines"*. (GMC100948, p213)

11. Side effects/adverse consequences of opiates

- The panel heard evidence about common side effects of the use of opiates.
- Professor Ford told the panel that, because of these side effects, *"when dealing with elderly patients, it was incumbent on prescribers to exercise extreme caution in determining dosage".* (GMC100948, p213)

12. The diamorphine/midazolam mix

- Dr Barton and Professor Sikora agreed that midazolam had a powerful sedating effect, and caution was needed when used with diamorphine.
- The panel noted that Professor Sikora had said that when treating a patient on the terminal pathway, the analgesic 'ladder' and guidelines were still necessary to avoid over-sedating *"because the danger otherwise is that one can end up with a patient who is unnecessarily unconscious or dead".* (GMC100948, p214)

13. Prescribing opiates outside the guidelines

- The panel accepted the evidence it heard from both medical experts and a number of consultants that, on occasion, it is necessary to prescribe outside the guidelines.
- Dr Barton's Counsel had put forward the argument that where there was no note of why she had prescribed outside the guidelines, the panel had no information on which to base a view that she had acted inappropriately and therefore those charges could not be proved. The panel members did not accept this argument and said that in those cases they had *"to review all the evidence and then ask themselves whether they could be sure on the basis of that evidence that [Dr Barton] had prescribed inappropriately"*. (GMC100948, p215)

14. Anticipatory prescribing and the delegation of powers

- The panel accepted that anticipatory prescribing was not an uncommon practice; it was designed to ensure that nursing staff had the discretion to prescribe medication without the necessity to wait for a doctor to respond to a call.
- The panel said that this prescribing carries risks, particularly where the prescription was for a syringe driver with a mixture of diamorphine and midazolam.
- It was Dr Barton's case that these risks were adequately protected by the fact that *"the drugs could only be administered by two fully qualified nurses working together; and that the nurses on Dryad and Daedalus were of a caliber that rendered the risk acceptable"* (GMC100948, p215). The panel said that Dr Barton made an *"apparent assumption"* that the required dose would increase. This

meant that the lowest dose in Dr Barton's anticipatory ranges was set at a higher level than the patient's current prescription.

- The panel said this carried a risk for nurses, if they could not get hold of a doctor in the circumstances envisaged by Dr Barton. If a nurse thought the lowest dose in the range was too high for their patient's needs, the only options were not to give the prescription at all, or to give it at too high a dose.
- The panel accepted Professor Ford's view that *"in anticipatory prescribing a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide"*. (GMC100948, p216)
- The panel said that while Dr Barton's practice of *"doubling up"* a dose which was not controlling pain would *"prevent the manifestation of breakthrough pain … it also greatly increased the risk of over-sedation and adverse side effects"*. (GMC100948, p216)
- In the panel's view, this practice demonstrated Dr Barton's approach to protecting patients from pain even at the cost of protecting them from over-sedation and adverse side effects.
- It was agreed that the doses actually administered never reached the highest doses in the ranges prescribed. The panel commented that this was fortunate. However, it went on to say: *"the fact remains that this method of prescribing gave rise to the risk that the highest doses could be administered. This is a matter which the Panel is obliged to take into account when considering the appropriateness of the prescribing and whether or not it was in the best interests of the patient."* (GMC100948, p216)

15. Syringe drivers

- A great deal of evidence was given in relation to syringe drivers. The panel concluded that there was value in their use.
- It noted that on Dryad and Daedalus wards, syringe drivers tended to be loaded with combinations of diamorphine and midazolam, frequently at doses of 20 mg of each, routinely doubling every 24 hours.
- On those wards, there were no facilities for intravenous hydration and thus patients who were unable to swallow, through unconsciousness or otherwise, would not receive hydration, which ultimately leads to death.
- The panel said: *"it was in this context that medical and nursing staff on these wards recognised that starting a patient on a syringe driver was an acknowledgement of the fact that the patient was now on a terminal pathway and not expected to live beyond a matter of days."* (GMC100948, p217)

16. Syringe drivers and the immediate relief of pain

- In its determination, the panel noted that Dr Barton had expressed surprise that Professor Ford had explained there could be a delay of up to 20 hours before analgesia administered through a syringe driver reached its optimum level. Dr Barton had said it was her experience that it took effect more quickly. When asked about the potential for dealing with immediate pain by single injection rather than placing the patient directly on a syringe driver, Dr Barton told Mr Kark: *"I was not in the habit of using intramuscular or subcutaneous Diamorphine in that way."* Mr Kark replied: *"Instead of which what you effectively did was handed the nurses the power to start the path for this lady's death."* Dr Barton responded: *"I did."* (GMC100948, p217)

17. Titration and the use of syringe drivers

- When treating a patient who had not previously been prescribed opiates (an opioid-naïve patient), Professor Ford said the first issue was to establish the level of analgesia needed to ensure that the patient was pain free but also remained alert and free of adverse side effects.
- The panel noted: *"in Professor Ford's view … this could most effectively be achieved by means of titration, ie, treating the patient with a series of escalating doses and observing the effect until a daily dose which completely controlled the pain was found."* (GMC100948, p218)
- When moving a patient who was already receiving opiates on to a syringe driver, nursing staff had the necessary conversion charts to calculate what the equivalent dose was and how to move to the syringe driver without increasing or decreasing cover during the transition.
- The panel noted the following exchange: *"When asked by Mr Kark about the need for titration prior to commencing a syringe driver, Professor Sikora said 'That would be the ideal situation to go for; to have either oral morphine or long-acting morphine, or in four-hour injections, work out over a two or three day period what the dose is, set that and then give the subcutaneous morphine.' He stated that unless you did that, there was a serious danger that you are either going to start too low or too high."* (GMC100948, p218)
- The panel went on to say: *"By contrast, you evinced a marked reluctance to titrate doses before commencing patients on syringe drivers. You told the Panel 'we simply did not have the level of staffing to do that on a ward of 24 people'."* (GMC100948, p218)
- The panel also noted that Dr Barton confirmed that, throughout the three years covering the 12 cases, titration was not carried out. The panel said she gave evidence saying: *"I was not taught it, I was not familiar with using it … it was not practical … it just was not feasible."* (GMC100948, p219)

18. The effect of staffing pressures on the prescribing practice

- The panel said that it had: *"received evidence from a wide range of witnesses that the impression given to the visitor to Dryad and Daedalus wards was that the wards were well run and that patients were taken good care of. You were full of praise for your nursing staff and the job they did. You were clear that the quality of nursing care that your patients received was not compromised by staffing pressures: you stated that opiates were never started earlier, or at a higher rate, because of inadequate staffing; you told the Panel that that would have been quite inappropriate. Your view on the effect of staffing pressures was borne out by Sister Joins and a large number of other witnesses."* (GMC100948, p219)
- However, the panel noted that Dr Barton also said her *"system of anticipatorily prescribing wide ranges of opiates for delivery by syringe driver with what some might view as a high starting dose, and in the absence of titration, was a direct and necessary result of staffing pressures."* (GMC100948, p219)
- The panel highlighted that the defence expert, Professor Sikora, had agreed this might be a reasonable proposition for an individual patient in distress and pain. That was because the staff would not have time to observe patients and increase medication in the optimal fashion.
- However, the panel also said the opposite might be true, as this strategy *"might conversely create the need for a higher level of observation if patients are to be*

adequately protected in the event that adverse consequences [from the higher doses of drugs] manifest themselves." (GMC100948, p219)

19. The role of consultants

- Much evidence was heard about the role of consultants. All three consultants gave evidence during the hearing. Dr Reid and Dr Jane Tandy gave evidence for the GMC. Dr Lord was called by Dr Barton.
- The panel said it had heard *"at the time in question, the presence of Consultants on Dryad and Daedalus wards was extremely limited. Although the Consultants who gave evidence before the Panel were supportive of you, their evidence tended to suggest that they had not critically examined your prescribing practice, and in many instances had not appreciated your admitted prescribing failures. Had they done so, this should have resulted in appropriate changes being made to your prescribing practice."* (GMC100948, p219)

20. Mr Langdale's argument that the very fact that senior medical staff and the visiting pharmacist did not object indicated that Dr Barton was doing nothing wrong

- The panel said: *"As stated above, the Panel took the view that the Consultants on the ward systematically failed to critically examine your prescribing practice. While the effect of this failure might have been to reinforce your view that you were not acting inappropriately, it in no way rendered your inappropriate conduct appropriate. The Panel noted that as a medical practitioner you retained ultimate responsibility for your own actions."* (GMC100948, p220)
- The panel also said: *"In respect of the pharmacist, the Panel has not had the advantage of receiving any evidence from her. In the circumstances, the Panel is unable to draw any conclusions with respect to your actions or inactions as a consequence of her actions or inactions. However, the Panel noted your admissions with regard to your own prescribing deficiencies, and that it has heard no evidence that these were detected and acted upon by the pharmacist."* (GMC100948, p220)

21. The principle of 'double effect'

- The panel heard evidence from Professor Ford about the 'double effect' of drugs given to seriously ill patients to palliate symptoms (that is, to relieve symptoms without treating the cause). The panel highlighted that Professor Ford had said that these types of drugs *"may lead to a shortening of life through adverse effects. That is well accepted as being a reasonable and appropriate aspect that may happen when one adequately palliates symptoms."* (GMC100948, p220)
- Professor Ford said that the issue of prescribing these drugs is to ensure the dose is high enough to have the necessary effect, but not to go beyond that. As an example, he said particular care needed to be given with drugs that sedate because they relieve distress but, at the same time, can produce respiratory depression and hasten death.
- The panel said that Dr Barton was *"clearly aware of the principle of double effect"* and when asked about the risk of her prescribing causing *"respiratory depression or lowering [a patient's] conscious level"*, the panel highlighted that Dr Barton said: *"I accepted that that was a price that we might have to pay in exchange for giving him adequate pain and symptom relief."* (GMC100948, p221)
- Throughout her evidence, Dr Barton said that her primary concern with such patients was that she did not wish them to be more alert to feel more pain. She

was prepared to accept the risks associated with the drugs in order to provide adequate analgesia and sedation.

- The panel said her answers *"gave a clear insight into how you viewed the desirability of balancing pain relief with the desirability of keeping the patient as free as practicable from the side effects of opiates".* (GMC100948, p221)

Fitness to Practise Panel determination: Part Two, formal findings of fact

6.140 Part Two set out the formal findings of fact:

- The panel noted that Dr Barton had admitted to some parts of the allegations.
- In relation to the unadmitted parts, the panel said it had borne in mind that the burden of proof rests on the GMC and that the standard of proof in this case was the criminal standard: *"namely that the Panel must be sure beyond reasonable doubt"* (GMC100948, p221).

Findings of fact: Mr Leslie Pittock (Patient A)

6.141 The findings of fact for Leslie Pittock, who had been admitted to Dryad Ward on 5 January 1996, were as follows (GMC100948, pp195–6, 222–4):

5–10 January 1996: Dr Barton prescribed diamorphine with a dose range of 40–80 mg daily

- **The Fitness to Practise Panel (FtP) found proved** that the lowest dose was too high.
- **FtP did not find proved** that the dose range was too wide.
- The panel accepted the view of Professor Ford that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle (GMC100948, p222).
- **Dr Barton admitted** that this created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that this was inappropriate.
- **FtP found proved** that this was potentially hazardous.
- **FtP found proved** that this was not in the best interests of Leslie Pittock.

11 January 1996: a new prescription was given, the diamorphine daily dose range was raised to 80–120 mg; midazolam was prescribed with a dose range of 40–80 mg daily

- **FtP found proved** that the lowest doses in the ranges were too high.
- **FtP did not find proved** that the dose range was too wide.
- The panel accepted the view of Professor Ford that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide (GMC100948, p222). This dose range did not offend against that principle.
- **Dr Barton admitted** that this created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that this was inappropriate.
- **Dr Barton admitted** that this was potentially hazardous.
- **FtP found proved** that this was not in the best interests of Leslie Pittock.

15 January 1996: a syringe driver was started with 80 mg diamorphine and 60 mg midazolam

- **FtP did not find proved** that the diamorphine administered was excessive to the patient's needs.
- The panel noted that Dr Barton attended the patient in person and exercised her clinical judgement. It said it could not, in those circumstances, be sure the doses were excessive.
- **FtP did not find proved** that this was inappropriate.
- **FtP found proved** that this was potentially hazardous.
- **FtP did not find proved** that this was not in the best interests of Leslie Pittock.

17 January 1996: the diamorphine dose was increased to 120 mg and midazolam to 80 mg

- **FtP did not find proved** that the diamorphine administered was excessive to the patient's needs.
- The panel noted that Dr Barton attended the patient in person and exercised her clinical judgement. It said it could not, in those circumstances, be sure the doses were excessive.
- **FtP did not find proved** that this was inappropriate.
- **FtP found proved** that this was potentially hazardous.
- **FtP did not find proved** that this was not in the best interests of Leslie Pittock.

January 1996: Dr Barton prescribed 50 mg nozinan in addition to other drugs

- **FtP found proved** that this prescription in combination with other drugs already prescribed was excessive to the patient's needs.
- **FtP found proved** that this was inappropriate.
- **FtP found proved** that this was potentially hazardous.
- **FtP found proved** that this was not in the best interests of Leslie Pittock.

Findings of fact: Elsie Lavender (Patient B)

6.142 The findings of fact for Elsie Lavender who had been admitted to Daedalus Ward on 22 February 1996 were as follows (GMC100948, pp196–7, 224–7):

24 February 1996: Dr Barton prescribed morphine slow release tablets, 10 mg twice daily

- **FtP did not find proved** that this prescription was inappropriate.
- The panel said it had noted Professor Ford's opinion that morphine slow release tablets 10 mg twice a day might be acceptable (GMC100948, p225).
- **FtP did not find proved** that this prescription was potentially hazardous.
- **FtP did not find proved** that this prescription was not in the best interests of Elsie Lavender.

26 February 1996: Dr Barton prescribed diamorphine with a dose range of 80–160 mg daily and midazolam with a dose range of 40–80 mg daily

- **FtP found proved** that the commencing doses of both drugs were too high.
- **Dr Barton admitted** that the dose ranges were too wide.

- **Dr Barton admitted** that the prescription was too wide and created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that Dr Barton's actions in prescribing the drugs were inappropriate.
- **Dr Barton admitted** that the prescriptions were potentially hazardous.
- **FtP found proved** that they were not in the best interests of Elsie Lavender.

5 March 1996: Dr Barton increased the dose range of diamorphine to 100–200 mg and midazolam to 40–80 mg daily; a syringe driver was commenced containing both drugs at the lowest doses

- **FtP did not find proved** that the lowest dose of diamorphine was too high.
- The panel noted that Dr Barton attended the patient in person and exercised her clinical judgement (GMC100948, p223). It said it could not, in those circumstances, be sure the doses were excessive.
- **FtP found proved** that the lowest dose of midazolam was too high.
- **Dr Barton admitted** that the dose ranges were too wide.
- **Dr Barton admitted** that the prescriptions created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that Dr Barton's actions in prescribing the drugs were inappropriate.
- **Dr Barton admitted** that the prescriptions were potentially hazardous.
- **FtP found proved** that the prescriptions were not in the best interests of Elsie Lavender.

The panel found in relation to management:

- **FtP found not proved** that Dr Barton did not perform an appropriate examination and assessment of Elsie Lavender.
- The panel noted GMC Counsel's concession that Professor Ford found no fault in this regard (GMC100948, p226).
- **FtP found proved** that Dr Barton did not conduct an adequate assessment as her condition deteriorated.
- **FtP did not find proved** that Dr Barton did not provide a plan of treatment.
- The panel said that whether it was adequate or not, there was a treatment plan; her family were told she was on the *"terminal pathway"* (GMC100948, p226).
- **Dr Barton admitted** that she did not obtain the advice of a colleague when the patient's condition deteriorated.
- **FtP found proved** that Dr Barton's actions and admissions in relation to the management of Elsie Lavender were inadequate.
- **FtP found proved** that Dr Barton's actions and admissions were not in the best interests of Elsie Lavender.

Findings of fact: Eva Page (Patient C)

6.143 The findings of fact for Eva Page who had been transferred to Dryad Ward on 27 February 1998 were as follows (GMC100948, pp197–8, 227–8):

3 March 1998: Dr Barton prescribed diamorphine with a dose range of 20–200 mg and midazolam with a dose range of 20–80 mg to be administered daily subcutaneously

- **Dr Barton admitted** that the dose ranges were too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that her action in prescribing these drugs was inappropriate.
- **Dr Barton admitted** that the prescribing was potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Eva Page.

Findings of fact: Alice Wilkie (Patient D)

6.144 The findings of fact for Alice Wilkie who had been transferred to Daedalus Ward on 6 August 1998 were as follows (GMC100948, pp198–9, 228–9):

On or before 20 August 1998: Dr Barton prescribed diamorphine with a dose range of 20–200 mg and midazolam with a dose range of 20–80 mg daily subcutaneously

- **Dr Barton admitted** that the dose ranges were too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** that her action in prescribing these drugs was potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Alice Wilkie.

Findings of fact: Gladys Richards (Patient E)

6.145 The findings of fact for Gladys Richards who was admitted to Daedalus Ward on 11 August 1998 were as follows (GMC100948, pp199, 229–30):

11 August 1998: Dr Barton prescribed 10 mg oramorphine (morphine oral solution) as required

- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that her actions in prescribing this drug were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Gladys Richards.

11 August 1998: Dr Barton prescribed diamorphine with a dose range of 20–200 mg and midazolam with a dose range of 20–80 mg daily subcutaneously

- **Dr Barton admitted** that the dose ranges were too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Gladys Richards.

Findings of fact: Ruby Lake (Patient F)

6.146 The findings of fact for Ruby Lake who had been admitted to Dryad Ward on 18 August 1998 were as follows (GMC100948, pp199–200, 230–1):

18 August 1998: Dr Barton prescribed 10 mg oramorphine in 5 ml as required

- **FtP did not find proved** that the prescribing was inappropriate.
- The panel noted this prescription was in response to complaints of pain by an opioid-naïve patient (GMC100948, p230). The panel said it was Dr Barton's view this was justified as she was exhibiting symptoms of congestive cardiac failure. The panel could not be satisfied this was inappropriate.
- **FtP found proved** that her action in prescribing this drug was potentially hazardous.
- **FtP did not find proved** that the prescribing was not in the best interests of Ruby Lake.
- The panel concluded that the prescription may, by its nature, be potentially hazardous but nonetheless in the best interests of the patient and not appropriate, and that was the case here (GMC100948, p230).

18–19 August 1998: Dr Barton prescribed diamorphine with a dose range of 20–200 mg and midazolam with a dose range of 20–80 mg daily subcutaneously

- **Dr Barton admitted** that the dose ranges were too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Ruby Lake.

Findings of fact: Arthur Cunningham (Patient G)

6.147 The findings of fact for Arthur Cunningham who had been admitted to Dryad Ward on 21 September 1998 were as follows (GMC100948, pp200–1, 231–2):

21 September 1998: Dr Barton prescribed diamorphine with a dose range of 20–200 mg and midazolam with a dose range of 20–80 mg daily subcutaneously

25 September 1998: Dr Barton wrote a further prescription of diamorphine with a dose range of 40–200 mg and midazolam with a dose range of 20–200 mg daily subcutaneously

- **Dr Barton admitted** that the dose ranges were too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Arthur Cunningham.

In relation to seeking advice:

- **Dr Barton admitted** that she did not obtain the advice of a colleague when Arthur Cunningham's condition deteriorated.

Findings of fact: Robert Wilson (Patient H)

6.148 The findings of fact for Robert Wilson who had been admitted to Dryad Ward on 14 October 1998 were as follows (GMC100948, pp201–2, 232–3):

14 October 1998: Dr Barton prescribed 10 mg oramorphine in 5 ml, with a dose of 2.5 ml to be given every four hours as needed

- **FtP found proved** (in light of Robert Wilson's history of alcoholism and liver disease) that this prescription was inappropriate.
- **FtP found proved** that this prescription was potentially hazardous.
- **FtP did not find proved** that it was likely to lead to serious and harmful consequences.
- The panel noted that the patient's alcohol-related liver disease fundamentally altered the prescribing situation (GMC100948, p232). Although the prescription was potentially hazardous, the panel was not able to be sure that it was likely to lead to serious and harmful consequences.
- **FtP found proved** that this prescription was not in the best interests of Robert Wilson.
- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that Dr Barton's actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Robert Wilson.

On or before 16 October 1998: Dr Barton prescribed diamorphine with a dose range of 20–80 mg daily subcutaneously

- **Dr Barton admitted** that the dose ranges were too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Robert Wilson.

On or before 17 October 1998: Dr Barton prescribed midazolam with a dose range of 20–80 mg daily subcutaneously

- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Robert Wilson.

In relation to seeking advice:

- **Dr Barton admitted** that she did not obtain the advice of a colleague when Robert Wilson's condition deteriorated.

Findings of fact: Enid Spurgin (Patient I)

6.149 The findings of fact for Enid Spurgin who had been admitted to Dryad Ward on 26 March 1999 were as follows (GMC100948, pp202–3, 234–5):

12 April 1999: Dr Barton prescribed diamorphine with a dose range of 20–200 mg and midazolam with a dose range of 20–80 mg daily subcutaneously

- **Dr Barton admitted** that the dose ranges were too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** that her action in prescribing these drugs was potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Enid Spurgin.

12 April 1999: a syringe driver was started with 80 mg diamorphine and 20 mg midazolam over 24 hours under Dr Barton's direction, but later the dose was reduced to 40 mg by Dr Q [Dr Reid]

In relation to assessment:

- Dr Barton did not properly assess Enid Spurgin upon admission.
- **FtP did not find proved** that this was inadequate.
- The panel noted that Dr Reid had assessed the patient shortly before her transfer, so accepted Professor Ford's view that it was not necessary for her to investigate the cause of pain at the time of admission, but it would have been necessary at a later stage (GMC100948, p234).
- **FtP did not find proved** that this was not in the best interests of Enid Spurgin.

Findings of fact: Geoffrey Packman (Patient J)

6.150 The findings of fact for Geoffrey Packman who had been admitted to Dryad Ward on 23 August 1999 were as follows (GMC100948, pp203–4, 235–7):

26 August 1999: Dr Barton gave verbal permission for 10 mg of diamorphine to be administered to the patient

- **FtP did not find** that this prescribing was inappropriate.
- The panel noted that Professor Ford was not critical and GMC Counsel conceded in his closing submission that it may be appropriate for this head to fail (GMC100948, p236).
- **FtP did not find** that this prescribing was potentially hazardous.
- **FtP did not find** that this prescribing was not in the best interests of Geoffrey Packman.

26 August 1999: Dr Barton prescribed diamorphine with a dose range of 40–200 mg daily subcutaneously

- **FtP did not find proved** that the lowest dose was too high.
- The panel said that, when applying the appropriate conversion rate, the panel calculated that the anticipatory prescription did not provide for an increase in the equivalent level of analgesia provided for in the existing prescription and was not therefore too high (GMC100948, p235).

- **Dr Barton admitted** that the dose range was too wide.
- **Dr Barton admitted** that the dose range created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Geoffrey Packman.

26 August 1999: Dr Barton also prescribed midazolam with a dose range of 20–80 mg daily subcutaneously

- **FtP found proved** that the lowest dose was too high.
- **Dr Barton admitted** that the dose range was too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **Dr Barton admitted** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that the prescribing was not in the best interests of Geoffrey Packman.

In relation to the management of the patient:

- Dr Barton saw Geoffrey Packman on 26 August 1999 and noted that he was *"not well enough to transfer to acute unit, keep comfortable, I am happy for nursing staff to confirm death".*
- Dr Barton did not consult with anyone senior about the future management of Geoffrey Packman, nor undertake any further investigations into his condition.
- **FtP found proved** that this was inappropriate.
- **FtP found proved** that this was not in the best interests of Geoffrey Packman.

Findings of fact: Elsie Devine (Patient K)

6.151 The findings of fact for Elsie Devine who had been admitted to Dryad Ward on 21 October 1999 were as follows (GMC100948, pp204–5, 237–9):

21 October 1999: Dr Barton prescribed morphine solution 10 mg in 5 ml, as required

- **FtP found proved** that this was not justified by Elsie Devine's presenting conditions.
- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Elsie Devine.

18 November 1999: following a deterioration in Mrs Devine's condition, Dr Barton prescribed fentanyl 25 micrograms, by patch

- **FtP found proved** that the prescribing was inappropriate.

- **FtP found proved** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Elsie Devine.

19 November 1999: Dr Barton prescribed diamorphine with a dose range of 40–80 mg daily subcutaneously

- **FtP found proved** that the lowest dose was too high.
- **FtP did not find proved** that the dose ranges were too wide.
- The panel noted Professor Ford's view that a dose range which allowed for an increase of more than 100% was too wide; this dose range did not offend against that principle (GMC100948, p238).
- **FtP found proved** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Elsie Devine.

19 November 1999: Dr Barton prescribed midazolam with a dose range of 20–80 mg daily subcutaneously

- **FtP found proved** that the lowest dose was too high.
- **FtP found proved** that the dose ranges were too wide.
- **FtP found proved** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that her actions in prescribing these drugs were potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Elsie Devine.

In relation to advice:

- **Dr Barton admitted** that she did not obtain the advice of a colleague when Elsie Devine's condition deteriorated.

Findings of fact: Jean Stevens (Patient L)

6.152 The findings of fact for Jean Stevens who had been admitted to Daedalus Ward on 20 May 1999 were as follows (GMC100948, pp205–6, 239–41):

20 May 1999: Dr Barton prescribed 10 mg oramorphine in 5 ml, 2.5–5 ml

- **FtP found proved** that there was insufficient clinical justification for such prescriptions.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that the prescribing was potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Jean Stevens.

20 May 1999: Dr Barton prescribed diamorphine with a dose range of 20–200 mg daily subcutaneously

- **FtP found proved** that there was insufficient clinical justification for such prescriptions.
- **Dr Barton admitted** that the dose range was too wide.
- **Dr Barton admitted** that the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **Dr Barton admitted** the prescribing was potentially hazardous.
- **FtP found proved** the prescribing was not in the best interests of Jean Stevens.

20 May 1999: Dr Barton prescribed midazolam with a dose range of 20–80 mg subcutaneously

- **FtP found proved** that there was insufficient clinical justification for such prescriptions.
- **Dr Barton admitted** that the dose range was too wide.
- **Dr Barton admitted** the prescribing created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that the prescribing was potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Jean Stevens.

21 May 1999: a further prescription was written by Dr Barton for 10 mg oramorphine in 5 ml, 4 times a day, 20 mg at night

21 and 22 May 1999: doses of oramorphine, diamorphine and midazolam were subsequently administered to the patient

- **FtP found proved** that there was insufficient clinical justification for such prescriptions.
- **Dr Barton admitted** that it created a situation where drugs could be administered which were excessive to the patient's needs.
- **FtP found proved** that the prescribing was inappropriate.
- **FtP found proved** that the prescribing was potentially hazardous.
- **FtP found proved** that the prescribing was not in the best interests of Jean Stevens.

In relation to advice:

- **Dr Barton admitted** that she did not obtain the advice of a colleague when Jean Stevens' condition deteriorated.

Findings of fact in relation to note taking

- Dr Barton did not keep clear, accurate and contemporaneous notes in relation to all 12 patients and Dr Barton admitted in particular that she did not sufficiently record,
  - i) the findings upon each examination
  - ii) an assessment of the patient's condition
  - iii) the decisions made as a result of examination
  - iv) the drug regime
  - v) the reason for the changes in the drug regime she prescribed and/or directed. (GMC100948, p206)

- **The FtP found proved** that Dr Barton did not sufficiently record the reason for the drug regime she prescribed.
- **Dr Barton admitted** that as a result her actions and admissions in keeping notes were inappropriate and were not in the best interests of her patients. (GMC100948, p240)

Findings of fact: failure to assess patients before prescribing opiates

- **The panel found proved** that Dr Barton failed to assess Alice Wilkie's (Patient D's) condition appropriately before prescribing opiates.
- The panel said that there was no documentary evidence to suggest that Dr Barton assessed Alice Wilkie, an opioid-naïve woman, prior to prescribing opiates (GMC100948, p228). Dr Barton had told the panel that she could not be sure she had formally assessed her as she was away around that time. On her return on 17 August 1998, there was *"mayhem occurring"* and although Dr Barton may have seen the patient, she would have relied upon the verbal reporting of assessments made by the nursing staff (p229).
- **The panel found proved** that this was not in Alice Wilkie's best interests.
- **The panel did not find proved** that Dr Barton failed to assess all other 11 patients' conditions appropriately before prescribing opiates.
- The panel said that, in view of the paucity of evidence in this regard, to which Dr Barton's own poor record keeping contributed, it could not be sure as to the appropriateness or otherwise of any assessment which she may have carried out (GMC100948, p206).

Fitness to Practise Panel determination: Part Three, serious professional misconduct

6.153 Part Three sets out the panel's determination that this was not a case where the findings of fact were insufficient to support a finding of serious professional misconduct. As a result, the panel needed to move on to consider *"the extent to which [the facts it had found proved] indicated serious professional misconduct"* and would then go on to consider sanctions (GMC100948, p241).

6.154 There was insufficient time to move to these considerations on 20 August 2009 and the hearing was adjourned for a date to be fixed.

Sanctions proceedings

6.155 This stage of the proceedings began five months later on 20 January 2010. The families complained to the GMC that this delay allowed Dr Barton's representatives to collect evidence from patients and supporters, which then influenced the panel. It was suggested by at least one of the families that the defence put pressure on patients to provide testimonials (GMC000199, p3).

6.156 The evidence initially provided during the fitness to practise hearing contained 195 testimonials (GMC101186, pp1–295). The evidence presented at the sanctions hearing contained 184 testimonials (GMC101128, pp1–289). Dr Barton's barrister explained during his submissions at the sanctions stage that his instructing solicitors had used the time since the determination to contact those who had given testimonials, in order to confirm that they still stood by their comments, in light of the findings (GMC000172, p62).

6.157 The legal test, guidance and case law for serious professional misconduct was set out by Counsel for the GMC (GMC000172, pp49–54). The legal assessor provided advice in relation to serious professional misconduct (GMC000172, pp24–43). On 29 January 2010, the panel gave its determination in public on serious professional misconduct.

6.158 In reaching its determination, the panel had to consider Dr Barton's conduct historically and decide whether *"looking at all the facts that have been admitted and found proved, Dr Barton's conduct amounts to a serious falling below the standard which might be expected of a doctor practicing in the same field of medicine in similar circumstances"* (GMC000172, p5).

6.159 The panel concluded that Dr Barton was guilty of multiple instances of serious professional misconduct and passed down the following judgement:

> "The Panel took account of [Counsel's submissions] and exercised its own judgement, having regard to the principle of proportionality and the need to balance the protection of patients, the public interest and Dr Barton's own interests." (GMC000172, p5).
>
> "The Panel made multiple findings of fact which were critical of Dr Barton's acts and omissions. These included but were not limited to:
>
> The issuing of prescriptions for drugs at levels which were excessive to patients' needs and which were inappropriate, potentially hazardous and not in the patients' best interests;
>
> The issuing of prescriptions for drugs with dose ranges that were too wide and created a situation whereby drugs could be administered which were excessive to the patient's needs;
>
> The issuing of prescriptions for opiates when there was insufficient clinical justification;
>
> Acts and omissions in relation to the management of patients which were inadequate and not in their best interests. These included failure to conduct adequate assessments, examinations and/or investigations and failure to assess appropriately patients' conditions before prescribing opiates;
>
> failure to consult colleagues when appropriate;
>
> acts and omissions in relation to keeping notes which were not in the best interest of patients, including failure to keep clear, accurate and contemporaneous notes in relation to patients, and in particular, in relation to examinations, assessments, decisions, and drug regimes." (GMC000172, pp5–6)
>
> "The Panel has concluded that Dr Barton failed to follow the relevant edition of 'Good Medical Practice' in relation to the following aspects of her practice;
>
> Undertaking an adequate assessment of the patient's condition based on the history and clinical signs, including where necessary, an appropriate examination;
>
> Providing or arranging investigations or treatment where necessary;
>
> Referring the patient to another practitioner where indicated;
>
> Enabling persons not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor;

Keeping clear accurate and contemporaneous patient records;

Keeping colleagues well informed when sharing the care of patients;

Ensuring suitable arrangements are made for her patients' medical care when she is off duty;

Prescribing only the treatment, drugs or appliances that serve patients' needs;

Being competent when making diagnoses and when giving or arranging treatments;

Keeping up to date;

Maintaining trust by;

- listening to patients and respecting their views
- treating patients politely and considerately
- giving patients the information they ask for or need about their condition, treatment and prognosis
- giving information to patients in a way they can understand
- respecting the rights of patients to be fully informed in decisions about their care
- respecting the right of patients to refuse treatment
- respecting the rights of patients to a second opinion

Abusing her professional position by deliberately withholding appropriate investigation, treatment or referral." (GMC000172, p6)

"Further, Dr Barton failed to recognize the limits of her professional competence.

The Panel has already commented at length on Dr Barton's defective prescribing practices, her inadequate note taking and her failures with regard to consultation, assessment, examination and investigation. It does not refrain from emphasizing and holding her to account for creating the risks and dangers attendant upon such conduct and omissions.

As a consequence of the Panel's findings of fact as outlined above, Dr Barton's departures from Good Medical Practice as outlined above, and the attendant risks and dangers previously commented on, the Panel concluded that she has been guilty of multiple instances of Serious Professional Misconduct." (GMC000172, p7)

6.160 The GMC regarded Dr Barton's position as presenting a continuing danger to patients, a view demonstrated by the following email sent from Peter Swain, GMC Head of Case Presentation, to Paul Philip, GMC Director of Fitness to Practise, on 7 August 2009:

"Paul, Dr Barton has expressed the view during the hearing that if put in the same situation again she would behave in the same way.

> The case raises very serious issues in relation to Dr Barton's misconduct and lack of insight as well as wider issues as to the message to be sent about standards to be expected of the profession in the highly sensitive area of management of patients with potentially terminal conditions.
>
> I am in no doubt that in terms both of patient protection and the wider public interest, the appropriate sanction submission is one of erasure." (GMC100115, p78)

6.161 Having found Dr Barton guilty of serious professional misconduct, the panel went on to consider what sanctions should be imposed. The panel heard submissions from both Counsel and received legal advice from the Legal Assessor (GMC000172, p7). It considered the then current Indicative Sanctions Guidance (GMC100825, pp32–68), set out all the matters it took into consideration and reminded itself that any sanction it imposed was not designed to punish Dr Barton, although it might have that effect (GMC000172, p7).

6.162 Mr Kark reminded the panel of the relevant parts of paragraphs 21, 22 and 23 of the Indicative Sanctions Guidance:

> "[paragraph 21] In deciding what sanction, if any, to impose, the Panel should have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. The Panel should consider the sanctions available starting with the least restrictive.
>
> [paragraph 22] Any sanction and the period for which it is imposed must be necessary to protect the public interest …
>
> [paragraph 23] … Whilst there may be a public interest in enable a doctor's return to **safe** practice, and panellists should facilitate this where appropriate in the decision they reach, they should bear in mind that the protection of patients and the wider public interest (ie, maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour) is the primary concern." (GMC000172, pp56–7).

6.163 Before giving its determination on the sanction to be imposed, the panel asked all parties to return to address them regarding the ten-year delay from the date of the last charges to the hearing (GMC000172, pp26–32).

6.164 Mr Kark made submissions that erasure was the appropriate sanction. The GMC did not concede that Dr Barton no longer posed a risk to the public. In addition, the public interest (in terms of both the family members of patients who had died and also the wider public) demonstrated that erasure was the only sanction that would ensure the protection of the public and public confidence in the profession (GMC000172, pp59–60).

6.165 Mr Langdale argued that the panel's charges showed that Dr Barton had exhibited an *"error of judgement"* and her overriding concern was to ensure that her patients did not suffer pain (GMC000172, p70). He argued that the appropriate order was for the conditions imposed by the IOC to continue and said that the 184 testimonials showed that Dr Barton was an excellent family doctor (GMC000172, p72).

6.166 During the course of his submissions, Mr Langdale had criticised the working conditions and in particular the supervision given to Dr Barton during her time at the hospital (GMC000172, pp68–9).

6.167 The panel said that it was *"no part of this Panel's role to make findings in respect of other persons who might have been the subject of criticism during the course of the evidence".* It also said:

> "Dr Barton's actions should not be judged in isolation. An injustice would occur were she to be judged the scapegoat for possible systematic failings beyond her control. Her actions must be judged in context. The Panel has had the benefit of hearing a great deal of evidence in that regard, and is well placed to define that context. This in no way detracts from Dr Barton's own personal responsibilities as a medical practitioner however." (GMC000172, p8)

6.168 When summarising the mitigation in relation to the offences, the panel:

> "… noted that Dr Barton was operating in a situation where she was denied the levels of supervision and safeguard, guidance, support, resources and training necessary to ensure that she was working within safe limits. Even when there was Consultant cover it was often of a caliber which gave rise to criticism during the course of evidence. The Panel accepted Mr Langdale's submission that the response of hospital management and senior colleagues against Dr Barton was such that she did, quite reasonably, feel that she was acting with the approval and sanction of her superiors." (GMC000172, p10)

6.169 On 29 January 2010, the Fitness to Practise Panel gave its determination on sanction. In setting out the approach it had taken in relation to the ten-year delay, the panel highlighted that there was no binding authority but it had followed the legal assessor's advice, which was:

> "… the passing of time served the Panel well in that it provides a context in which Dr Barton's attitudes and practices could be viewed and judged. It allowed the Panel to judge the efficacy of conditions as a workable sanction by opening a ten year window through which to view it." (GMC000172, p11)

6.170 The panel first summarised its findings, having *"made multiple adverse findings of fact in respect of Dr Barton's prescribing practices, note keeping, consulting colleagues, assessments, examinations and investigations"* and multiple instances of serious professional misconduct (GMC000172, p8). It set out the aggravating features and mitigating features of the offences and then the mitigation personal to Dr Barton (p9).

6.171 The panel then turned to consider the available sanctions, beginning with the least serious. The panel said that it *"had no hesitation in concluding that given the seriousness and multiple instances of her professional misconduct it would be insufficient, inappropriate and not proportionate either to take no action or to issue her with a reprimand"* (GMC000172, p12).

6.172 The panel then turned to consider the next most serious sanction, conditions. It said that it was unable to accept that Dr Barton no longer posed a risk to patients, but because she had been in safe practice for ten years, conditions may be formulated to meet that risk (GMC000172, p13).

6.173 The panel distinguished Dr Barton's case from the highly publicised case of Harold Shipman and made it clear that, in its view, this was not such a case. However, it said it took *"an extremely serious view"* of actions that put patients at risk and had *"no hesitation"* in deciding that, even when considering the intervening ten years, it was necessary to take action *"in order to maintain public confidence in the profession"*. This was to *"send a message to the public that the profession will not tolerate Serious Professional Misconduct"* (GMC000172, p14).

6.174 The panel said that it was satisfied conditions might be formulated which would maintain public confidence in the profession. It was *"greatly impressed by the many compelling testimonials which detailed Dr Barton's safe practice over the last ten years"* (GMC000172, p14). Although neither the panel nor the GMC was responsible for the rehabilitation of doctors, the panel said that it could be argued it was in the public interest to preserve Dr Barton's services as a GP (GMC000172, p14).

6.175 The panel decided that an order for three years was appropriate and proportionate for the protection of patients, with 11 conditions. The first seven conditions imposed on Dr Barton were as follows:

1. She must notify the GMC promptly of any post she accepts for which registration with the GMC is required and provide the GMC with the contact details of her employer and the PCT on whose Medical Performers List she is included.
2. At any time that she is providing medical services, which require her to be registered with the GMC, she must agree to the appointment of a workplace reporter nominated by her employer, or contracting body, and approved by the GMC.
3. She must allow the GMC to exchange information with her employer or any contracting body for which she provides medical services.
4. She must inform the GMC of any formal disciplinary proceedings taken against her, from the date of this determination.
5. She must inform the GMC if she applies for medical employment outside the UK.
6. Regarding opiates:
    a. She must not prescribe or administer opiates by injection. If she prescribes opiates for administration by any other route she must maintain a log of all her prescriptions for opiates including clear written justification for her drug treatment. Her prescriptions must comply with the BNF guidance for such drugs.
    b. She must provide a copy of this log to the GMC on a six-monthly basis or, alternatively, confirm that there have been no such cases.
7. She must confine her medical practice to GP posts in a group practice of at least four members (including herself). (GMC000172, p15)

6.176 The record of the hearing shows that *"There was a general outcry of disapproval from members of the public who then left the hearing chamber"* (GMC000172, p16).

6.177 The further four conditions were then read out:

8. She must obtain the approval of the GMC before accepting any post for which registration with the GMC is required.
9. She must attend at least one CPD (Continuous Professional Development) validated course on the use of prescribing guidelines within three months of the date from which these conditions become effective and forward evidence of her attendance to the GMC within one week of completion.
10. She must not undertake palliative care.
11. She must inform the following parties that her registration is subject to the conditions above: any organisation or person employing or contracting with her to undertake medical work; any locum agency or out-of-hours service she is registered with or applies to be registered with (at the time of application); any prospective employer or contracting body (at the time of application); the PCT in whose Medical Performers

> List she is included, or seeking inclusion (at the time of application); her Regional Director of Public Health. (GMC000172, p16)

6.178 The panel was satisfied that these conditions *"provide further safeguards for the protection of patients"* (GMC000172, p16).

6.179 In assessing the maximum period of three years as appropriate, the panel said that the sanction would be reviewed before the end of that period. If the review hearing then decided that the conditions were still necessary, a further order could be made (GMC000172, p17).

6.180 The documents show how Dr Barton benefited from the delay before the fitness to practise process took place. The ten-year delay was interpreted as ten years of good practice to weigh in the balance. The Gosport Independent Panel notes that the decision on the sanction to be imposed on Dr Barton was taken 19 years after the nurses had first expressed concerns, as described in Chapter 1.

6.181 The decision on sanctions prompted an email response to the GMC from Mrs Reeves, who was clearly unhappy, not just with the outcome but also with the conduct of the hearing (GMC100017, pp13–15).

6.182 On 29 January 2010, Niall Dickson, Chief Executive of the GMC, issued a press release, which said:

> "We are surprised by the decision to apply conditions in this case. Our view was the doctor's name should have been erased form the medical register following the Panel's finding of Serious Professional Misconduct. We will be carefully reviewing the decision before deciding what further action, if any, may be necessary." (GMC100825, p433)

6.183 Mrs Reeves immediately wrote to the GMC complaining that the press release *"was an absolute joke"* (GMC100017, p8).

6.184 The website for the British Medical Association (BMA) states that the association is the trade union and professional body for doctors in the UK. It represents the needs and interests of doctors. On 2 March, Dr Hamish Meldrum, its Council Chair, wrote to Professor Peter Rubin, Chair of the GMC, to formally put on record the BMA Political Board's *"extreme disquiet"* that Mr Dickson had criticised the decision of the Fitness to Practise Panel. The BMA described this as *"inappropriate and an unwelcome departure from established practice"* and *"tantamount to an interference in due process"* (GMC000729, p1).

6.185 In correspondence with Mrs Reeves, Mr Dickson stressed that the GMC's view was that Dr Barton's name should have been erased from the register. He told her:

> "We are now asking the government to give us the right of appeal to the High Court in cases where we believe the Panel outcome is too lenient or could put patients at risk … Under our proposed reforms a senior judge will head up the new tribunal service … Our frustration with the existing system is that the panels are autonomous (and rightly so) but we cannot challenge their decisions." (GMC100022, p13)

6.186 In 2010, the only mechanism to appeal the sanction decisions of the Fitness to Practise Panel was if the Council for Healthcare Regulatory Excellence (CHRE) (which was informed of the outcome of all GMC hearings) referred the case to the High Court for an appeal. Members of the public and interested parties had no right of appeal.

6.187 On 3 February, the GMC instructed Leading Counsel to advise on whether or not the GMC should support such a referral if the CHRE were to make one. If the CHRE were to refer the case to the High Court for an appeal, such an appeal would have to have been lodged by 1 April 2010.

6.188 The CHRE held a case meeting on 23 March, adjourned until 29 March. The CHRE set out the test it had to apply *"when considering 'undue leniency'"* was:

> "… whether the decision was one which the Panel, having regard to the relevant facts and to the objective of the disciplinary proceedings, could reasonably have imposed. The question is whether the decision of the Panel was 'manifestly inappropriate' having regard to Dr Barton's conduct and the interests of the public [CHRE v Ruscillo [2004] EWCA Civ 1356]. The Members noted that it was not enough that they themselves might have come to a different view." (GMC100426, pp9–14)

6.189 The CHRE concluded that, although the members considered erasure to be the most appropriate sanction, the test had not been met to refer the case to the High Court for an appeal (GMC100426, p14).

6.190 The CHRE issued a news statement setting out that it considered the fitness to practise decision to be *"lenient but not unreasonable in law"*. It expressed sympathy for the families concerned with the deaths of patients but highlighted that *"medical regulation is not about punishment or blame but about whether or not a doctor is fit to practice medicine"*. It explained why the CHRE did not agree with the GMC panel's decision but stated that the CHRE had decided *"it was reasonable in law for them to reach that conclusion"* (GMC100426, p6).

6.191 Having received this determination from the CHRE, the GMC had no other avenues of appeal. Mr Dickson issued a press release, which said:

> "This was a complicated and difficult case which has caused anguish and upset to a great many people. We understand and support the view of the CHRE that Dr Barton should have been erased from the medical register but also understand and accept the legal position in relation to an appeal." (GMC101302, p961)

No GMC action on the consultants

6.192 The documents available to the Gosport Independent Panel include limited references to the consultants.

6.193 On 21 March 2002, at Dr Barton's second IOC hearing, the Committee asked Counsel for the GMC for:

> "… clarification as to whether the Committee is entitled to know what is [the consultant's] role in this matter, as is set out in the Hampshire Constabulary letter [06 February 2002]. There is implicit criticism there of the consultant in charge. Are we entitled to know whether that particular consultant has been referred to the Council, or whether the police are continuing their investigations … It may be that could be relevant to the part that this doctor has played relative to the consultant." (GMC101057, p20)

6.194 Counsel replied:

> "I can certainly say that, so far as any police investigations are concerned, they are concluded, and there are no police investigations on going into [the consultant]. I wonder if I may take instructions on the other matter? [Having taken instructions] I have no instructions on any other action taken against [the consultant]." (GMC101057, p20)

6.195 The IOC identified that the role of consultant *"could be relevant"*. The GMC did not take this hint and there is no documentation available to the Panel to suggest that it took any further action to investigate who the consultants were, what their roles were or what part they had played in the problems at the hospital at this time.

6.196 The documents show no explanation as to why the GMC did not ask for a formal screening decision on the consultant. By this stage, the GMC knew that there were at least five cases of similar prescribing.

6.197 On 20 November 2002, the police had a meeting with the GMC to provide information about Operation Rochester. During the meeting, the police observed:

> "… although there was a theme developing through the cases to suggest 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." (GMC101057, p437)

6.198 On 19 January 2007, Eversheds (the solicitors instructed by the GMC at this time) attended a meeting with the police, to discuss disclosure from the Operation Rochester investigation (GMC101181, p85).

6.199 The solicitors *"asked if the police looked at the possibility of prosecuting any other Doctors/Medical Staff as part of the investigation"*. The police said that no charges had been brought against any of the consultants who had supervised Dr Barton, some of whom had been interviewed under caution on a voluntary basis (GMC101181, pp88–9).

6.200 In a conference call on 30 October, lawyers for the GMC, including Mr Kark and an investigation officer for the GMC, considered the available information about named consultants:

> "[The] concern is that we will be criticised if we go ahead with only one doctor when we have got evidence against other doctors … Is there a case against these doctors? TK [Tom Kark] said that Dr Barton says that these consultants regularly reviewed the prescriptions … TK said we either prosecute the doctors, take statements or leave them alone … TK will prepare some advice on this at the same time as the draft charges." (GMC101302, p794)

The investigation officer confirmed that these would be under the new rules and to add new complaints against two of the consultants, who could only be criticised for supervision, would be a major headache (GMC101302, p794).

6.201 The GMC asked Mr Kark for further advice after the completion of its investigation into Dr Barton.

6.202 In relation to one of the consultants, his advice was that a prosecution would not be appropriate (GMC100133, p6). In fact, the records show that three days after Mr Kark had made his closing submissions in the fitness to practise hearing, she *"was voluntarily erased from the register on 7 August 2009 … therefore the GMC cannot take any action against this doctor"* (GMC100187, p669). There is no evidence that the consultant's application for voluntary erasure was communicated to the GMC department investigating the events at the hospital and bringing the case against Dr Barton. It would have been open to the GMC to consider whether to allow voluntary erasure to take place when a doctor was under investigation.

6.203 In relation to another consultant, Mr Kark advised that prosecution would be disproportionate, given the working arrangements at this local community hospital.

6.204 The documents were sent to Helen Gately, Assistant Registrar at the GMC, who on 9 February 2011 provided her decision on whether or not the allegations could be brought, despite the delay of over five years, because *"it is in the public interest, in the exceptional circumstances of the case"* (GMC100187, p668).

6.205 The Assistant Registrar considered the cases of two of the consultants and agreed with Mr Kark's advice that the GMC had been aware of these allegations since July 2002. She said that while it would be *"difficult to justify the very lengthy delay"*, she also had to look at the effect of that delay (GMC100187, p672).

6.206 The Assistant Registrar's conclusion was that *"on the spectrum of the gravity of allegations, it is my view that the allegations are not grave enough to be capable of constituting 'exceptional circumstances' in the public interest that would require waiver of the five year rule"* (GMC100187, p672).

6.207 The Assistant Registrar added that these two consultants did not pose an unwarranted risk to the public as they had not been brought to the attention of the GMC previously. The concerns did not appear to reflect a pattern of behaviour and so it was not considered to be in the public interest in the exceptional circumstances of the case for the allegations to proceed. Nor was it considered to be in the public interest, to maintain public confidence in the profession and the allegations did not need to be ventilated further by a public body (GMC100187, pp668–74).

6.208 In taking this stance, the GMC confirmed its decision not to extend its proceedings beyond Dr Barton.

Other points raised by the GMC's handling of its investigations

6.209 The documents show some limited consideration given to the position of Professor Christopher Bulstrode, a former GMC Council member. Professor Bulstrode is Dr Barton's brother. At a meeting on 18 May 2009 between the GMC and FFW, among the items discussed was the *"Issue with Dr Barton's brother being a former Council member – we agreed this is unlikely to be of any significance and agreed to clarify exactly who has confirmed this"* (GMC000802, p19).

6.210 On 30 January 2010, Charles Stewart-Farthing, a family member, sent an email to the GMC, expressing his disgust and dissatisfaction that Dr Barton had not been removed from the register. In the email, he said: *"The allegations of nepotism regarding her brother being a member of the GMC, to be found on the internet, would appear to have foundation, so **what is going on?**"* (GMC100129, p42).

6.211 The response sent to Mr Stewart-Farthing dealt with other parts of his email, but not the request for information about Dr Barton's brother. This was, perhaps, because Mr Swain had sent an internal email which said: *"I wouldn't bother replying to the references to her brother. There isn't a serious suggestion of foul play, only passing references to unsubstantiated assertions"* (GMC100129, p41).

6.212 In response to a Freedom of Information Act request from Mrs Reeves, on 28 January 2011, the Information Access Officer for the GMC said:

> "Professor Bulstrode was an elected member of Council from 1 July 2003 to 31 December 2008. Professor Bulstrode also served on the Resources Committee from September 2003 to September 2005, on the Education Committee from September 2003 to October 2008, and was a trustee of the GMC pension scheme from November 2003 to March 2008." (GMC000346, p1)

6.213 The Information Access Officer said:

> "With regards to whether Professor Bulstrode ever sat on any fitness to practise panels; I should explain that in November 2004 a decision was made by the Council to exclude any Council members from sitting on fitness to practise panels. Therefore, Professor Bulstrode would not have sat on a fitness to practise panel after November 2004. We have checked our records of sittings of the Committee on Professional Performance, the Professional Conduct Committee, the Assessment Referral Committee and the Health Committee between 1 July 2003 and 30 November 2004. I can confirm that we have no record of Professor Bulstrode having sat on any of these panels." (GMC000346, pp1–2)

6.214 The Information Access Officer continued:

> "In relation to our knowledge of the relationships between Professor Bulstrode and Dr Barton, I can confirm that the suggestion that they are related was put to our Press Office by a journalist in the summer of 2009. We were not aware of the relationship prior to this. Given that Professor Bulstrode was not a Council member at the time of the hearing, and as a Council member from 2003-2008 would have had no involvement or influence in the case, we did not pursue this." (GMC000346, pp1–2)

6.215 One of the questions asked by Mrs Reeves was: *"Did any of the fitness to practise panel know Dr Jane Barton or Professor Bulstrode personally?"* (GMC000884, p4). The GMC responded: *"… there would be no expectation on the panellists to declare such an association as Professor Bulstrode was in no way connected with the case. Therefore, we are not aware of whether any of the panellists knew Professor Bulstrode personally"* (GMC000347, p2).

6.216 This answer did not include the additional details contained in a GMC internal email on 13 January 2011:

> "I also looked at our training records to see if any of the Barton panel may have attended a training session which Prof Bulstrode would have attended in his role as a Council member. There was a training session in September 2005 which both Professor Bulstrode and Dr Roger Smith attended. As you know, however, no individual cases are discussed at training. Council members attend to talk about Council policy and future developments in general terms." (GMC000884, p1)

Dr Roger Smith was a panellist at Dr Barton's fitness to practise hearing.

6.217 On 31 January 2013, the GMC was asked if Professor Bulstrode had been admonished for failing to declare this interest in his sister's case (GMC100041, p3). The GMC replied:

> "I can confirm that we do have a signed copy of Professor Bulstrode's statement of commitment to the code of conduct dated 2/6/2003 which included a section for the declaration of interests. The form does not mention Dr Jane Barton. Please note that the guidance issued in 2003 contained specific reference to the interest that should be declared … the list did not extend to specifically cover the declaration of a family association to a registered doctor. We have therefore decided that a GMC investigation is not warranted and we will not be taking further action." (GMC100041, p6)

6.218 On 4 March, the GMC gave a further explanation:

> "Clearly if a family member who was a doctor had a case coming before a Fitness to Practise panel a panellist would be required to declare an interest, but that was not what happened in Professor Bulstrode's case. By the time his sister's case was being considered he was no longer a Council Member and so was not obliged to declare anything." (GMC100041, pp11–14)

6.219 The GMC was asked if Professor Bulstrode attended GMC meetings with Professor David Black. The GMC responded on 16 December 2013 to say that it had *"not been able to find any records that we hold that suggest that Professor Black attended any GMC meetings with Professor Bulstrode or that Professor Black discussed the Gosport War Memorial Hospital deaths at any GMC meeting"* (GMC000134).

6.220 The families had raised a legitimate question of a potential conflict of interest involving Professor Bulstrode, Dr Barton's brother. The documents show that the issue had not been considered before it was raised by family members; and that, when it was considered, there was a lack of candour in not disclosing the evidence of a possible connection between Dr Smith, a member of the Fitness to Practise Panel, and Professor Bulstrode.

Conclusion: what is added to public understanding

- **Concerns about events at Gosport War Memorial Hospital were first brought to the attention of the General Medical Council in 2000. There is no suggestion from the documents that the General Medical Council was notified, either by the Royal College of Nursing or by the NHS, about the concerns expressed by nurses in 1991. Nor is there any suggestion that the General Medical Council was notified by Hampshire Constabulary or Portsmouth HealthCare NHS Trust, or anyone else, when concerns were expressed about the death of Gladys Richards.**

- **The documents are significant in assessing what weight should be given to Dr Jane Barton's workload. The Panel has seen nothing in the documents to indicate that she raised concerns about her workload until she was in the process of being investigated. Dr Barton herself noted that she did put her concerns about the levels of nursing and medical staff in writing, but not until 2000.**

- **The documents show that the General Medical Council pursued concerns about Dr Barton's prescribing through five interim orders proceedings. An order was made on the fifth occasion.**

- The Panel also notes that the General Medical Council was not clear about the terms of the voluntary agreement. Even in July 2008, as the interim order was being considered, its Counsel was misquoting the agreement despite the fact that a copy had been provided at the time of the previous Interim Orders Committee in October 2004. Given the importance of the issues, it is surprising to find that there was confusion on this key element of the argument.

- By accepting the police's request, the General Medical Council's investigation effectively stalled. As a result, the hearing which had been set for April 2003 did not take place until June 2009. By the time of the sanctions hearing there had been a ten-year delay which in itself affected the sanction which was imposed. The Panel notes this as one of a number of examples of a process of accountability being undermined by deferring to another organisation.

- The documents show how Dr Barton benefited from the delay before the fitness to practise process took place. The ten-year delay was interpreted as ten years of good practice to weigh in the balance. The Gosport Independent Panel notes that the decision on the sanction to be imposed on Dr Barton was taken 19 years after the nurses had expressed concerns, as described in Chapter 1.

- The documents show that the General Medical Council had evidence against other doctors but decided to confine its investigations to Dr Barton.

- The families had raised a legitimate question of a potential conflict of interest involving Professor Christopher Bulstrode, Dr Barton's brother. The documents show that the issue had not been considered before it was raised by family members; and that, when it was considered, there was a lack of candour in not disclosing the evidence of a possible connection between Dr Roger Smith, a member of the Fitness to Practise Panel, and Professor Bulstrode.

Chapter 7: The Nursing and Midwifery Council

Introduction

7.1 In 2002, the Nursing and Midwifery Council (NMC) replaced the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) as the statutory regulator for nurses and midwives in the UK. As with its predecessor, the central functions of the NMC are described as being, *"to establish standards of education, training, conduct and performance for nurses and midwives and to ensure the maintenance of those standards".*

7.2 The NMC's main objective is to safeguard the health and well-being of persons using or needing the services of its registrants. As with the UKCC before it, the NMC is responsible for dealing with cases of alleged misconduct by nurses and midwives.

7.3 The Royal College of Nursing is a membership organisation and trade union which represents nurses and nursing. It has an in-house legal team and acts for its members when the NMC brings disciplinary proceedings against them.

7.4 The documents show that no referral was made to the UKCC, as it was then called. This chapter explains what the NMC did from the point at which it succeeded the UKCC in September 2000 up until its Preliminary Proceedings Committee (PPC) considered allegations against seven nurses. The chapter concludes by looking at a further complaint and communication with families.

How the Nursing and Midwifery Council became involved

7.5 As part of the second police investigation described in Chapter 5, Lesley Lack and Gillian Mackenzie, daughters of Gladys Richards, provided witness statements to the police which were critical of the care provided to Mrs Richards and also referred to the nursing staff. Mrs Lack gave her statement on 31 January 2000 (FAM003525). Mrs Mackenzie provided a witness statement to the police on 6 March 2000 in which she was critical of the actions of the nurse involved (BLC003731).

7.6 The documents show that Hampshire Constabulary did not make the UKCC aware of these criticisms at the time. On 18 September 2000, Detective Chief Inspector (Det Ch Insp) Raymond Burt wrote to the UKCC informing it that an investigation had begun into whether a woman had been unlawfully killed at the Gosport War Memorial Hospital in 1998. Det Ch Insp Burt asked *"whether there are any matters recorded which might be relevant to our investigation in terms of [the nurse's] Professional competence"* (HCO000941, p2).

7.7 The UKCC appears to have treated Det Ch Insp Burt's enquiry as a request for information sharing rather than a complaint. The Panel has not seen evidence of any further contact

between the UKCC and the police until May 2001 when the UKCC contacted Det Ch Insp Burt to let him know that, having been prompted by the Department of Health, it had reviewed its position in respect of the nurse and was seeking a meeting with the police (HCO000635).

7.8 The UKCC met with Hampshire Constabulary on 15 May 2001. A confidential briefing was provided by the police about the investigation into the nurse but no formal disclosure was made (HCO000635). Later that day, Liz McAnulty, Director of Professional Conduct at the UKCC, wrote to Mike Woodford, the Force Solicitor for Hampshire Constabulary, explaining that the UKCC had not interpreted Det Ch Insp Burt's letter from September 2000 as being a complaint against the nurse. She asked whether Hampshire Constabulary *"believe that [the nurse's] conduct should be investigated by the UKCC, and whether your investigations so far have revealed any information about [the nurse's] conduct which may warrant his interim suspension from the register"* (HCO003123, p2).

7.9 The police disclosed material to the UKCC about those nurses who, on the advice of Professor Brian Livesley, a consultant physician at Chelsea and Westminster Hospital, might have had a degree of criminal culpability in relation to the treatment of Mrs Richards. The material disclosed to the NMC was limited to what had already been disclosed to the individuals when interviewed by the police and comprised the witness statements prepared by Mrs Mackenzie and Mrs Lack as well as the hospital notes for Mrs Richards (HCO000635, p148; HCO000913).

7.10 Det Ch Insp Burt wrote to the UKCC on 18 May 2001 stating that Professor Livesley had expressed a view that the two relevant staff nurses might have a measure of criminal culpability in respect of the treatment of Mrs Richards and enquiring whether either had been the subject of complaint or investigation by the UKCC (HCO000861). In response, the UKCC sought clarification as to whether the police were making a complaint against the two relevant nurses, as *"the UKCC can only investigate allegations against registrants in response to a complaint … the situation is that if you are making a complaint against the three nurses, we are obliged to investigate"* (HCO005416, p3).

7.11 On 21 May, Hampshire Constabulary wrote to the UKCC stating that Det Ch Insp Burt's letter to the UKCC in September 2000 was not considered to constitute a complaint against one of the nurses because the police had no authority to make a complaint against him (HCO000914).

7.12 On 29 May, the UKCC informed the police that it had decided to open a file for the cases of the three relevant nurses (HCO000911).

The Nursing and Midwifery Council investigation: before Operation Rochester

7.13 On 21 June 2001, the Fareham and Gosport Primary Care Trust (PCT) responded to a letter from the UKCC. It described the circumstances of Mrs Richards' admission to the hospital, the complaint that the family had made to the PCT and the investigation that the PCT subsequently undertook (DOH700267). On 27 July, the PCT provided the UKCC with the material generated as a result of the complaint made to the PCT by Mrs Lack (DOH102868). This included the letter from Mrs Lack as well as the PCT's investigation report, which found no evidence of wrongdoing by any of the nurses (NMC100090, p222).

7.14 On 14 August, Hampshire Constabulary informed the UKCC that, following advice from the Crown Prosecution Service, no criminal prosecutions would be brought against the three relevant nurses (HCO003876).

7.15 On 18 September, the PPC of the UKCC convened to consider the cases of these nurses in relation to the treatment of Mrs Richards at the hospital. The PPC represented the first of a two-stage process which applied at the time (NMC100090).

7.16 The PPC carried out the following functions:

- investigations into cases of alleged misconduct
- determination of whether or not to refer a case of alleged misconduct to the Professional Conduct Committee with a view to removing practitioners from the register
- determination of whether or not to refer a case of alleged misconduct to professional screeners for consideration of a practitioner's fitness to practise
- determination of whether a practitioner was guilty of misconduct and, if so, whether it was appropriate to issue a caution as to their future conduct.

7.17 The PPC noted that the referral had been made by Hampshire Constabulary as part of the criminal investigation into the circumstances of Mrs Richards' death. It was noted that the family's main concerns were as follows:

> "1. On 12 August when first admitted to Gosport her agitation was put down to dementia when in fact it could have been simply that she wanted the toilet. She could have been treated with a milder form of pain relief.
>
> 2. When she suffered her fall a doctor should have been called before she was moved back to her chair.
>
> 3. On 13 August, it took a long time for staff to identify that she had suffered a fall. Her distress was continually put down to her dementia and she was not admitted to Haslar A and E until 24 hours after the fall.
>
> 4. On 17 August when she was returned to Haslar Hospital she was obviously in extreme pain from being positioned wrongly. Why was nothing done about this until Mrs lack arrived and assisted the nurse to move her.
>
> 5. When Mrs Richards developed a haematoma why was a decision made to do nothing other than to keep her pain free." (NMC100090, p8)

7.18 The UKCC report noted that no specific allegations had been made against the three practitioners but identified concerns raised by Mrs Richards' family in respect of the conduct of each nurse. The UKCC report proposed that, for the following reasons, no action should be taken against the nurses:

> "1. The police are not proceeding with any criminal prosecution of any practitioner.
>
> 2. The Trust's findings do not support any allegations of misconduct.
>
> 3. The family's complaints are mainly about the medical treatment received by Mrs Richards, although they have identified some mistakes and delays in the system their evidence does not provide proof to the required standard of professional misconduct by any practitioner." (NMC100090, p9)

7.19 Under the process in place at the time, when the UKCC had investigated a case and considered that it might lead to the removal of a practitioner from the register, it would write to the practitioner involved and then consider referral to the Professional Conduct Committee. In this case, the UKCC decided to take no further action.

7.20 The Panel notes that the PPC relied upon the Trust's findings and upon the decision not to take criminal proceedings rather than conducting its own enquiries. Mrs Richards' family were not informed of the decision of the PPC because they were not considered to be the complainants (NMC100090, p6).

7.21 On 6 February 2002, Hampshire Constabulary disclosed to the UKCC expert reports prepared by Professor Livesley, Dr Keith Mundy, a consultant geriatrician, and Professor Gary Ford, a medical professor at Newcastle University (HCO003853). At the same time, the reports were disclosed to the Hampshire and Isle of Wight Strategic Health Authority (HCO501408). On 11 February, Liz McAnulty responded for the UKCC, noting that as the police were not going to conduct any further inquiries, and given that the UKCC had to apply a similar standard of proof to matters of fact, it would not be progressing matters any further (HCO003121).

7.22 Liz McAnulty's letter prompted Detective Superintendent (Det Supt) Jonathon (John) James to respond on 21 February setting out the terms of the police inquiry. He highlighted the fact that the police investigation concerned the criminal offence of gross negligence manslaughter and said: *"this seems to me to be very different from determining, to the same standard of proof, that nursing or medical staff have failed to deliver care to the appropriate professionally recognised standards".* Det Supt James went on to say:

> "The reports previously forwarded to you were only a small part of the information gathered during the course of our investigations. In order to enable UKCC to discharge its functions as a regulatory body I have authority to share all information with you in addition to the material already supplied. I would stress that our enquiries have focused upon the potential criminal liability of individuals. I nor any other member of the enquiry team, have not, and could not, have come to an informed conclusion about the standard of care delivered by individual doctors or nurses against any recognised professional benchmark. Nevertheless, it appears that there is a prima facie case for enquiries to be commenced to establish whether or not individuals concerned in the care of patients described in the reports of Ford, Livesley and Mundy have failed to meet professional standards of care." (HCO501396, pp1–2)

7.23 On 13 February, Det Supt James wrote to family members who had made complaints about the treatment of their loved ones while in the hospital. While stating that there would be no further criminal investigation into the deaths, Det Supt James informed family members that the reports commissioned as part of the investigation had been forwarded on to the regulatory authorities, including the UKCC, which could *"Initiate further enquiries or act upon the reports as they deem appropriate".* (See, for example, HCO003912.)

7.24 The documents show that the UKCC asked the Trust for comments on Professor Ford's report but took no other action. The Trust responded on 15 May, indicating that it would take no disciplinary action against any of the nurses named (NMC100012, p2).

7.25 Family members contacted the NMC (which had succeeded the UKCC) in 2002, expressing their concerns about the hospital:

- On 17 May, Bernard (Barney) Page made a formal written complaint about the treatment of his late mother, Eva Page, by the nurses involved. He considered that there were *"several areas of grave concern"* (NMC100338, p11).
- On 1 June, Marilyn Jackson made a formal complaint to the NMC about the *"appalling level of care"* given to her mother, Alice Wilkie, prior to her death at the hospital in August 1998. The complaint referred to the nursing staff generally and to a nurse by name (IMI000178).
- On 6 June, Ann Reeves wrote to the NMC lodging a formal complaint against the nurses involved in respect of the treatment of Mrs Reeves's mother, Elsie Devine. Mrs Reeves stated that her mother had received treatment that was tantamount to *"abuse"* and that *"those involved in our Mother's care are inhumane and a poor representation of the medical profession"* (NMC100338, pp7–8).
- On 19 June, Marjorie Bulbeck wrote to the NMC to register a formal complaint about the nursing care provided to her mother, Dulcie Middleton. The complaint referred to the conduct of individual nurses (albeit unnamed) and the poor standard of nursing care generally, stating that *"some nurses were uncaring and had an unprofessional attitude to vulnerable helpless patients"* and *"lacked humanity"* (NHE000584, p4). Mrs Bulbeck later wrote to the NMC naming a nurse as being responsible for the *"appalling care my Mother received whilst at the Gosport War Memorial Hospital"* (NMC100325, p358).
- On 22 August, Rita Carby wrote to the NMC lodging a formal complaint against the nursing staff alleging *"complete negligence"* on the part of the relevant nurses in the treatment of her husband, Stanley Carby (NMC100325, p372).

7.26 The NMC passed Mrs Bulbeck's complaint on to the Trust (NHE000586, p2). The PCT referred the NMC to the report of an investigation carried out by Jane Williams, Nurse Consultant in Stroke Care. The report of the investigation, prepared by Fiona Cameron, Operational Director at the PCT, noted that the nursing documentation was inadequate and found certain concerns in relation to the treatment of Mrs Middleton but did not find evidence of any misconduct by a named nurse (NMC100325, pp363–5).

7.27 The NMC also referred the complaint from Mrs Carby to the Trust, which commissioned Professor Jean Hooper to prepare a report (DOH800992). Professor Hooper's report concluded that, while there were discrepancies in the nursing records in terms of dates and times, she was *"unable to find any specific reason through review of the notes to indicate that the nurses were negligent in their care and management of Mr Carby"* (NMC100325, p377).

The Nursing and Midwifery Council investigation: during Operation Rochester

7.28 The complaints from Mrs Jackson, Mrs Reeves and Mr Page were referred to the PPC which, on 24 September 2002, considered the cases against four relevant nurses (NMC100323). Shortly before the PPC convened to consider these cases, Hampshire Constabulary reopened the investigation into the deaths at the hospital and initiated Operation Rochester to consider the circumstances surrounding the deaths of 90 patients. The PPC therefore decided to adjourn its own consideration of these cases pending the outcome of the further police investigation. The family members who had brought the complaints were informed of this decision on 27 September (NMC100268, NMC100269, NMC100272). Similar letters were sent to Mrs Bulbeck and to Mrs Mackenzie (NMC100267, NMC100270).

7.29 While it had the power to suspend the registration of any of the nurses pending the outcome of the police investigation, the PPC chose not to do so. The documents show no record of the reasons for this decision (NMC100327).

7.30 In October 2004, Hampshire Constabulary met with Liz McAnulty to brief her about Operation Rochester and to discuss the basis on which the information held by the police, and in particular the findings of the Key Clinical Team (KCT), could be disclosed to the NMC (HCO000641, p32). The briefing highlighted how the KCT had divided the cases into three categories: Category 1 (acceptable treatment), Category 2 (suboptimal care but no evidence of unlawful criminal activity) and Category 3 (warranting further detailed investigation to determine whether unlawful activity could be identified). The Category 3 cases were the subject of continued investigation by the police (NMC100012, p3).

7.31 As of 12 October, 19 of the Category 2 cases had been provided to the General Medical Council (GMC) and it was proposed that they would also be provided to the NMC. The police were keen to ensure that the material was provided on the basis that it would be used in private PPC hearings and that there would be no adverse publicity prior to the conclusion of any criminal investigation and proceedings that might follow (HCO001599).

7.32 The documents show that the police's request that matters be heard in private and without publicity created difficulty for the NMC. Complaints against some nurses had already been considered by the PPC, and had been adjourned pending the outcome of the police investigation. This was an important distinction. Where an allegation was received by the NMC before 1 August 2004 but proceedings had not commenced by that date, the matter would be dealt with under the procedures previously in place. Subsequent complaints, or other cases referred to the NMC, would be dealt with under the new procedures (the New Rules). In respect of all cases, however, in preliminary hearings the NMC would be required to disclose material to the registrant, expert witnesses, complainants or third parties.

7.33 The procedures for allegations received by the NMC on or after 1 August 2004 were governed by the New Rules. These provided a process whereby the Investigating Committee could make interim suspension orders or impose conditions on a practitioner's registration while an investigation was ongoing or where a matter had been referred by the Investigating Committee to the Conduct and Competence Committee but no final hearing had taken place. The Investigating Committee could make such an order if it was satisfied that it was necessary for the protection of members of the public or was otherwise in the public interest, or was in the interests of the person concerned. If the Investigating Committee considered that there was a case to answer, it refers the case to the Conduct and Competence Committee.

7.34 Under the New Rules, the NMC's Investigating Committee had the power to make interim orders. However, these hearings ordinarily took place in public, unless it was considered to be in the interests of a third party or in the public interest for the hearings to be held in private. Any interim order imposed on a practitioner had to be made public under the New Rules. In this case, the NMC was therefore unable to give categorical reassurance that there would be no publicity relating to hearings before the Investigating Committee if an interim order was considered necessary; nevertheless, the NMC would make representations that the hearing should take place in private. The NMC also confirmed that, ordinarily, no substantive hearing would take place before the conclusion of a criminal investigation (HCO007108).

7.35 It was agreed between the NMC and Hampshire Constabulary that before any material was released into the public domain by the NMC, the police would be given the opportunity to discuss their position with the NMC (HCO002261).

7.36 On 9 November, the NMC received files for 19 of the Category 2 cases containing the following material generated by the KCT:

- nursing expert report from Irene Waters (a summary of the significant information from patient records)
- relevant extracts from the report of Dr Robin Ferner (expert in pharmacology)
- relevant extracts from the report of Dr Peter Lawson (geriatrician)
- relevant extract from the report of Dr Anne Naysmith (palliative care)
- case review by Matthew Lohn, solicitor and partner at Field Fisher Waterhouse (NMC100086, p91).

7.37 The police also provided the NMC with the medical records for each patient. Clare Strickland, the in-house lawyer at the NMC, considered the papers that had been received but accepted that *"without further assistance [she] lacked the medical/practical expertise to be able to identify any evidence of misconduct"* (NMC100086, p91). She expressed the view that the NMC may have required an expert to consider the cases and identified Irene Waters – who had actually been a member of the KCT (p91). Irene Waters formed part of a five-person team charged with the duty of screening each case according to whether the overall care received was negligent, sub-optimal or optimal and whether the death had been natural or not. The team had not been instructed to identify specific issues of nursing care (see paragraph 7.30).

7.38 Clare Strickland began to review the files herself and formed the view that:

- the evidence in the case of the treatment of Mrs Page was insufficient to proceed against two relvant nurses
- in respect of the treatment of Mr Carby, it would be possible to prove that the nurse had failed to record the time of her nursing notes entries on 27 April 2004, but this alone would not be sufficient evidence of misconduct
- there was also no evidence of misconduct by the two nurses in respect of the treatment of Mr Carby (NMC100086, pp88–9).

7.39 Hampshire Constabulary continued to deliver files related to the Category 2 cases throughout December (NMC100086, p131) and by January 2005 had delivered 47 cases (p130). On 12 January 2005, the NMC told the police that it was unlikely to take any immediate further action in respect of the Category 2 cases which had been served on it and that any action it might take in the future would have to follow the conclusion of criminal proceedings (p127). Further boxes of files were sent to the NMC by the police in September and November 2005 (p120). The police continued to investigate the Category 3 cases and it was not until December 2006 that it was announced that there would be no criminal prosecution in relation to any of the deaths at the hospital.

The period following Operation Rochester

7.40 By February 2007, two months after the Crown Prosecution Service's decision that there would be no criminal prosecutions, the NMC still had not received disclosure in respect of the ten Category 3 cases (NMC100086, p100). The NMC had received complaints about the treatment of five patients: Mrs Page, Mr Carby, Mrs Wilkie, Mrs Devine and Mrs Middleton. Clare Strickland had carried out a review of two of those cases (Mrs Page and Mr Carby) and considered that there was no case to answer in respect of any of the nurses named. The other three cases had not been reviewed.

7.41 Clare Strickland had reviewed the police reports, expert reports and case summaries prepared by Mr Lohn for the 76 cases provided to the police as part of Operation Rochester. She noted that there was *"no direct criticism of any named nurse in any of the expert reports"*, although there were examples of named nurses being criticised by family members (NMC100086, p69).

7.42 The ten Category 3 cases were provided to the NMC in March 2007 (NMC100086, p42). Clare Strickland reviewed them and concluded that the only files in which family members had expressed criticism of individual nurses were those of Arthur Cunningham and Mrs Devine. Of the 80 Category 1 and Category 2 cases only five contained material in which there had been expressions of dissatisfaction with named nurses (Mr Carby, Margaret Queree, Mrs Wilkie, Mrs Richards and Mrs Middleton). In respect of Mrs Richards, the case had been closed by the PPC (NMC100010). The lawyer acknowledged that she did not review every document provided:

> "This is partly because I lack the clinical expertise to review medical records, but also because to review these files fully would be a full-time job lasting weeks and I do not have this sort of time available at present." (NMC100012, p4)

7.43 Three years later she felt able to reassure the police, if asked, that:

> "… every single case they passed to us was reviewed. I read all of the material provided, with the exception of the medical records, although I did refer to them when there was anything in the other material that led me to them. None of the expert reports contained any criticism of any named nurse. None of the police summaries of their contacts with the relatives contained anything amounting to an allegation against a named nurse or nurses." (NMC100097, p4)

It is important to note that none of the experts engaged by Hampshire Constabulary had been asked to consider the position of the standard of nursing conduct in any case. Nor did any of the experts, asked to provide full reports, have the requisite expertise to deal with these issues.

7.44 The documents provided to the Panel show the NMC's dismissal of the material supplied by the police as not warranting action but do not provide evidence of the basis on which the assessment was made. In respect of the five cases subject to complaint, Clare Strickland was of the view that there was insufficient evidence of misconduct on the part of any of the nurses referred to in the papers, save for the possibility of the failure of certain nurses to challenge the inappropriate prescribing administered by Dr Jane Barton in the cases of Mrs Wilkie and Mrs Devine. However, Clare Strickland did not appear to consider it necessary to obtain expert evidence on this matter, or on any other matter, despite her own acknowledgement that she did not have the medical/practical expertise to identify evidence of misconduct.

7.45 On 20 April 2007, Clare Strickland suggested that the next stage of the process would be to seek a meeting with the GMC in order to obtain information about the progress of its proceedings (NMC100012, p19).

7.46 The meeting with the GMC took place over a year later, in May 2008. By that time the GMC investigation was at an advanced stage. The Coroner had opened inquests into the ten Category 3 deaths and the GMC took the view that the disciplinary proceedings against Dr Barton should not take place until the conclusion of those inquests (PCO000279, NMC100039). The GMC considered that the NMC should not do anything that would discourage nurses from giving evidence at any GMC hearing to determine Dr Barton's fitness

to practise. Clare Strickland was of the view that any proceedings that the NMC brought against the nurses should wait until the outcome of the GMC proceedings had been determined (NMC100086, pp34–6).

7.47 As Chapter 8 shows, the inquests into the ten deaths began in March 2009 and concluded in April 2009. In the interim, the NMC instructed Leading Counsel who, in February 2009, provided advice as to how the NMC should proceed (NMC100034). Counsel was not provided with all the paperwork but relied on the summary prepared by Clare Strickland. On this basis, Counsel concurred with her view that there was insufficient evidence to proceed with an allegation of misconduct against any nurse in the cases of Mrs Page, Mr Carby and Mrs Middleton. Counsel also took the view that there was no case to answer in respect of some of the allegations that had been made against the nursing staff in the cases of Mrs Wilkie and Mrs Devine. However, Counsel was of the opinion that there was *"a possible case of failure to challenge/report inappropriate prescribing"* (p12) in the cases of Mrs Wilkie and Mrs Devine.

7.48 Counsel had not been provided with any of the papers in relation to any of the remaining cases. She was therefore unable to advise on whether there was any prospect of establishing misconduct in those cases. However, Counsel was able to advise that these additional cases would fall to be determined under the new (and more flexible) rules that had been in force since 2004 (NMC100034). Counsel also expressed her opinion that the NMC had *"acted entirely properly in postponing disciplinary proceedings pending the outcome of investigations by the police and the subsequent inquests and the GMC proceedings"* (NMC100034, p12). However, Counsel also said that the cases adjourned by the PPC in September 2002 and the additional two complaints made in 2002 should be placed before the PPC as soon as possible. The PPC could decide to adjourn all the cases until the conclusion of the inquests and the GMC hearings or could deal with them immediately. The result would be that the cases involving Mrs Page, Mr Carby and Mrs Middleton would be closed immediately and the cases of Mrs Wilkie and Mrs Devine would be closed as well or postponed until the conclusion of the GMC proceedings.

7.49 The NMC was unable to arrange a meeting of the PPC before the inquest was due to start in March 2009. Clare Strickland took the view that it would be *"undesirable to arrange for the PPC meeting to take place whilst the inquest is ongoing"* and that, in any event, *"the PPC is unlikely to adopt any course other than adjourn pending the outcome of the inquest"* (NMC100105).

7.50 Following the conclusion of the inquests in April 2009, the NMC decided that the hearing before the PPC would not take place until the conclusion of the GMC hearing, which was scheduled for August 2009 (NMC100086, p5). It was envisaged that the hearing before the PPC would take place in early October 2009 (NMC100069).

7.51 On 21 August 2009, the findings of fact stage of the GMC hearing concluded. The Disciplinary Panel said that there was insufficient time to determine if Dr Barton's actions amounted to misconduct or to decide whether or not a sanction should be imposed. The case was relisted for a sanction hearing in January 2010 (NMC100077).

7.52 Clare Strickland was of the view that while the GMC's findings *"were not determinative… [they were] a relevant factor for the PPC to take into account. The key issue is whether the GMC finds that the doctor's actions amount to serious professional misconduct"* (NMC100079). The decision was therefore taken to once again postpone the PPC hearing until the GMC hearings had concluded (NMC100114). The GMC proceedings concluded on 29 January 2010.

7.53 In November 2009, Christopher Green, solicitor at the Royal College of Nursing, emailed a Senior Case Officer in the Fitness to Practise Division of the NMC. Mr Green informed the Senior Case Officer that he was representing seven nurses who had been referred to the NMC and requested information in relation to the allegations that had been made. In January 2010, the NMC responded, giving the background to the referrals and a brief outline of the complaints, and proposing that the matter should be put before the PPC in late March/early April 2010 (NMC100122, p3).

7.54 On 17 March 2010, the Senior Case Officer wrote to the following nurses informing them that a complaint had been made against them:

- The nurse in respect of the treatment of Mr Carby (NMC100209)
- The nurse in respect of the treatment of Mrs Devine (NMC100220)
- The nurse in respect of the treatment of Mrs Devine (NMC100221)
- The staff nurse in respect of the treatment of Mrs Page and Mrs Devine (NMC100222)
- The sister in respect of the treatment of Mrs Devine and Mrs Page (NMC100224)
- The nurse in respect of the treatment of Mr Carby (NMC100229)
- The nurse in respect of the treatment of Mrs Wilkie, Mrs Middleton and Mr Carby (NMC100240).

Their cases were being referred to the PPC and would be considered together at a two-day hearing to be held on 11 and 12 April.

The Preliminary Proceedings Committee hearing into the five complaints

7.55 The PPC members were provided with a bundle of documents prepared on behalf of the NMC: Professor Ford's report; the CHI report; an investigation overview provided by Hampshire Constabulary; relevant transcripts from the inquests and the GMC hearing, as well as copies of the letters of complaint; and clinical notes and drug charts and nursing notes (where available) in respect of each of the five patients whose cases were being considered (NMC100325, p33). The PPC members were provided with responses prepared on behalf of each of the nurses (NMC100191).

7.56 The PPC members were also provided with a copy of a report prepared by Clare Strickland setting out the background to the referrals, the history of complaints at Gosport War Memorial Hospital and the police investigations, as well as the inquests and GMC proceedings (NMC100325, pp11–32). The report set out the evidence on misconduct and the conclusions on whether there was a case to answer.

7.57 The nurses faced the following allegations.

The relevant nurse

"In respect of Patient A (Alice Wilkie):

- Failed to maintain accurate patient records:

  (i) On 17 August 1998, by writing a note suggesting that her daughter, Mrs Jackson, had agreed to a syringe driver for Patient A and that active treatment was not appropriate;

(ii) On 21 August 1998, wrote in Patient A's clinical notes that her family had been present when she had died when they had not been;

- On 20 August 1998, failed to ascertain the level of pain Patient A was in;
- On 21 August 1998, failed to monitor Patient A appropriately and keep her family informed of her condition;
- On 21 August 1998, failed to monitor Patient A appropriately and keep her family informed of her condition." (NMC100325, p7)

"In respect of Patient B (Dulcie Middleton):

- Failed to ensure that meals were provided within her reach and on an occasion on an unknown date, without cutlery;
- Failed to ensure that her alarm bell was within her reach so that she could call for assistance;
- Failed to ensure that Patient B was kept warm;
- Failed to ensure that Patient B received basic nursing care or was treated with dignity." (NMC100325, p7)

"In respect of Patient C (Stanley Carby)

- Was negligent in the care provided to Patient C." (NMC100325, p7)

The relevant sister on the ward

"In respect of Patient D (Eva Page)

- Failed to act in the interests of Patient D." (NMC100325, p8)

"In respect of Patient E (Elsie Devine)

- Failed to act in the interests of Patient E by failing to remove a fentanyl patch from her until three hours after the morphine syringe driver has started;
- Failed to provide accurate information to Patient E's family when you telephoned that morning, in that you said that while she was confused you denied there was any urgency in family members attending;
- Returned clothes provided by Patient E's family by saying that they were 'too good' for a hospital stay (as they were dry clean only);
- Failed to ensure accurate patient notes were maintained for Patient E in that there was an incorrect statement in the notes on 3 November 1999 that she could not climb stairs. A kidney infection was diagnosed and antibiotics started, but this was not written up in the notes.

At a subsequent independent review meeting relating to the care provided to Patient E:

- Suggested that she was agitated on the morning of 19 November 1999, but none of the family had ever seen her agitated.
- Made an unprofessional comment about tension between Mrs Reeves and her sister-in-law." (NMC100325, p9)

The relevant staff nurse

"In respect of Patient D (Eva Page)

- Failed to act in the interests of Eva Page." (NMC100325, p9).

"In respect of Patient E (Elsie Devine)

- Failed to provide the family of Patient E with any explanation about her medication.
- Failed to adequately account to Patient E's family for her sudden deterioration." (NMC100325, p9)

The relevant nurse

"In respect of Patient C (Stanley Carby)

- Failed to maintain accurate patient records in respect of Patient C, in that you failed to record the time in entries on the contact record.
- Was negligent in the care provided to Patient C." (NMC100325, p9)

The relevant nurse

"In respect of Patient C (Stanley Carby)

- Was negligent in the care provided to Patient C." (NMC100325, p9)

The relevant nurses

"Named as part of Anne Reeves' complaint against the nursing care provided to her mother, Elsie Devine." (NMC100325, p10)

7.58 In respect of all the allegations against each of the nurses concerned, the PPC declined to proceed (NMC100150). In respect of certain allegations, the PPC found that even if the facts were proven, it would not lead to the removal of the nurse from the register. In respect of other allegations, the PPC considered that the alleged behaviour was *"not capable of amounting to misconduct"*.

7.59 In addition to the matters set out in the list of allegations, the PPC also considered certain nurses' actions in commencing patients on syringe drivers. The PPC found that, in respect of each of these allegations, the conduct of the nurses was not capable of amounting to misconduct and, therefore, declined to proceed with the matter (NMC100150).

7.60 On 1 June 2010, the Senior Case Officer wrote to the various complainants (NMC100207, NMC100208, NMC100233, NMC100234, NMC100235) and nurses (NMC100144, NMC100156,

NMC100177, NMC100186, NMC100189, NMC100151, NMC100147) informing them of the decision reached by the PPC not to proceed with any of the allegations and of the reasons given by the PPC in support of its decision.

A further complaint: Mr Cunningham

7.61 In June 2009, Charles Stewart-Farthing gave evidence at the GMC proceedings involving Dr Barton regarding the treatment of his stepfather, Mr Cunningham. On 24 June 2009, Mr Stewart-Farthing wrote to the NMC suggesting that the relevant sister and nurses *"all had a hand in [Mr Cunningham's] demise"* (FAM102585).

7.62 The NMC responded by stating that the case would undergo an initial screening assessment and then requested further information (NMC100304, NMC100302). In October 2009, Mr Stewart-Farthing completed a consent form that allowed the NMC to disclose to the nurses concerned the information that a complaint had been made against them (NMC100295).

7.63 Five months later, on 30 March 2010, the NMC again wrote to Mr Stewart-Farthing requesting evidence specifying what the relevant nurses had done wrong. The NMC specifically asked for Mr Stewart-Farthing's stepfather's *"medical notes, or anything else (e.g. witness statements) which depicts the actual actions of the nurses with regards to the treatment of your step-father"* (NMC100301).

7.64 On 18 May, the NMC wrote to Mr Stewart-Farthing in these terms:

> "As no response was received from you and due to the lack of direct evidence, the decision has been made to close this case. This is because without specific evidence regarding each nurse, the case is 'not in the form required' to enable progression to our panel." (NMC100294)

7.65 In dismissing Mr Stewart-Farthing's complaints about the role played by nurses in the death of his stepfather Mr Cunningham, the records show no evidence that the NMC investigated his complaint. The Panel is surprised by the NMC's approach to the complaint raised by Mr Stewart-Farthing. Requests were made of Mr Stewart-Farthing for evidence upon which potential allegations could be made. However, the matters that were being raised by Mr Stewart-Farthing related to events that took place nearly a decade earlier. Furthermore, Clare Strickland had received evidence in relation to Mr Cunningham from the police and had, in March 2007, been able to identify criticisms of individual nurses made by Mr Cunningham's family.

Communication with families

7.66 This chapter shows that no referral was made to the UKCC, as it then was, until September 2000. The documents reveal what the NMC did or did not do from that point to the decision of its PPC in April 2010 to decline to proceed in respect of all the allegations against each of the seven nurses concerned (NMC100150). The documents also reveal the almost complete lack of communication between the NMC and the families between August 2002 and June 2010 when they were told of the outcome. By its own admission, the NMC had been dedicated in that period to maintaining contact with the official bodies involved.

7.67 The documents show particular problems in the NMC's communications with the family of Mrs Richards. The PPC decided in September 2001 not to proceed with the allegations but neither Mrs Mackenzie nor Mrs Lack, Mrs Richards' daughters, were informed. A year later, the

NMC wrote to both Mrs Mackenzie and Mrs Lack wrongly suggesting that the investigation into the circumstances of their mother's death had been adjourned. The NMC was aware that it had made a mistake in this matter by, at the latest, May 2008 (NMC100086, p36). The records show that no attempt was made to communicate with the family for nearly two years (NMC100226, NMC100231).

7.68 The NMC recognised that its level of communication with the complainants had been poor. In a file note prepared by the Senior Case Officer, he noted that:

> "… while the NMC had been dedicated to maintaining contact with Hampshire Constabulary, the coroner's office, the Trust, the GMC and its agents, on review it is recognised that better work should have been done at the time about engaging with those members of the public that have made complaints directly to the NMC." (NMC100176, p4)

7.69 The documents show that Norman Lamb MP, then the Liberal Democrat Health spokesman, had written to the NMC's Chief Executive in November 2009 (NMC100357, NMC100356). In reply, Professor Dickon Weir-Hughes acknowledged:

> "I accept that we could have been more pro-active in our engagement with those members of the public who had raised this issue with us. Notwithstanding some of the limitations about what we could have said about progress at various stages, I acknowledge that we could – and should - have kept patients, relatives and others with a key interest in the case better informed about developments and I would like to assure you that we will seek to improve on this aspect." (NMC100343)

Conclusion: what is added to public understanding

- **On 29 May 2001, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting informed Hampshire Constabulary that it had decided to open a file for the cases of three relevant nurses.**
- **The Panel notes that the Preliminary Proceedings Committee in effect relied upon Portsmouth HealthCare NHS Trust's findings and upon the decision not to take criminal proceedings rather than conducting its own enquiries. The family of Gladys Richards were not informed of the Preliminary Proceedings Committee's decision not to proceed with the allegations because they were not considered to be the complainants.**
- **The documents show the Nursing and Midwifery Council's dismissal of the material supplied by the police as not warranting action, but they do not provide evidence of the basis upon which their assessment was made. In respect of the five cases subject to complaint, Clare Strickland, the in-house lawyer for the Nursing and Midwifery Council, was of the view that there was insufficient evidence of misconduct in respect of any of the nurses referred to in the papers, save for the possibility of the failure of certain nurses to challenge the inappropriate prescribing administered by Dr Jane Barton in the cases of Alice Wilkie and Elsie Devine. However, the lawyer did not consider it necessary to obtain expert evidence in this matter, or in respect of any other matter, despite her own acknowledgement that she did not have the medical/practical expertise or the time to identify evidence of misconduct.**

- **The Nursing and Midwifery Council was extremely cautious in seeking not to undermine or in any way prejudice any of the other investigations. The length of the police investigation, the time spent before the inquests took place and then the subsequent time taken in the General Medical Council proceedings all meant that the delay before the Preliminary Proceedings Committee hearing took place was excessive.**

- **The documents also reveal the almost complete lack of communication between August 2002 and June 2010 when the families were told the outcome. By its own admission, the Nursing and Midwifery Council in that period had been dedicated to maintaining contact with the official bodies involved.**

Chapter 8: The inquests

Introduction

8.1 In the period from 2002 to 2006, the documents show how Hampshire Constabulary updated the Coroner – first James Kenroy and, from 2003, David Horsley – on the progress of Operation Rochester (HCO004539, p3; PCO000082). In December 2006, the Crown Prosecution Service (CPS) decided that there would be no criminal prosecutions (CPS002008).

8.2 The CPS decision cleared the way for inquests to be held. Mr Horsley formed a provisional view on holding inquests into the ten deaths of the Category 3 cases (HCO002544). This chapter explains what the documents reveal about the inquest process for those cases from that point, including the protracted delay at the start and the basis on which some cases were included in the inquests while others were not. The chapter goes on to explain what the documents show in the case of Gladys Richards, which was not one of the Category 3 cases referred by the police.

8.3 In some circumstances, inquests can proceed through a public inquiry. Only a government minister can establish a public inquiry under the Inquiries Act 2005. Ordinarily when this decision is made a Coroner must suspend his investigation. There is no set rule as to when an inquiry, instead of an inquest, should take place. However, it has been stated that inquiries may be preferable to inquests where public concern extends significantly beyond a death itself to wider related issues.[1] This chapter shows how the Coroner raised this possibility, which was then rejected.

8.4 The chapter concludes by considering what the documents show about: the legal representation of families and the associated funding; the argument that the inquests should have proceeded on the basis that Article 2 of the Human Rights Act was engaged; the possible application of Rule 43 of the Coroners Rules 1984, where the Coroner believes that action should be taken to prevent the recurrence of similar deaths; the decision to hold the inquests with a jury; and the treatment of expert evidence.

What happened before the inquests were opened

8.5 Following the CPS decision in December 2006 not to bring criminal proceedings, Mr Horsley's workload meant that he did not hold a meeting with the police until 11 April 2007, when they provided a file of material (HCO002530, PCO000292–PCO000324). Crucially, while this file did contain a summary of the investigation, the evidence that was produced focused solely on the ten deceased. The focus of the coronial investigation at this stage was clearly to be on these ten and no more.

1 House of Lords Select Committee on the Inquiries Act, 2005. *The Inquiries Act 2005: Post-Legislative Scrutiny*, 11 March 2014, HL 143, 2013–2014, paragraphs 87–8.

8.6 One of the difficulties that the Coroner faced at the outset was that, in respect of seven of the Category 3 cases, the bodies had been cremated. Pursuant to section 8(1) of the Coroners Act 1988, a Coroner can only open an inquest into a death when the body of the deceased is lying within his district. Mr Horsley formed the view that he would need the permission of the Secretary of State to open inquests into the seven deceased who had been cremated as the bodies had been destroyed by fire. Application to the Secretary of State in this regard was made on 15 June 2007 (PCO000058).

8.7 From the very early stages of his involvement, Mr Horsley was concerned that the inquests into the ten deaths would put considerable strain on the Portsmouth and South East Hampshire Coroner's Office, both in terms of the financial cost of conducting the inquests and of staff resourcing issues. At a meeting with the Department of Health (DH) and the Ministry of Justice, Mr Horsley said that *"the ordinary work of the jurisdiction would be very seriously affected"*, and that he could not organise these inquests with his present complement of administrative staff and officers (PCO000128).

8.8 By June 2007, Mr Horsley had identified Andrew Bradley as a suitable person to undertake the inquests on his behalf (HCO002469). However, Mr Bradley was not appointed as an Assistant Deputy Coroner for South East Hampshire until April 2008, meaning he was unable to undertake any work on the inquests before then. It appears that Mr Bradley was chosen as he was the part-time Coroner for North East Hampshire, based in Basingstoke, and had recently retired from private practice as a solicitor. This meant *"he would have the time to do the inquests and is familiar with the local police etc., etc."* (MOJ000010).

8.9 Shortly after writing to the Secretary of State for permission to open inquests into the seven deceased who had been cremated, Mr Horsley contacted the Ministry of Justice, indicating that he considered that a public inquiry might be preferable to an inquest (PCO000059, pp4–5).

8.10 On 21 August 2007, a meeting was held between Mr Horsley, representatives of the Ministry of Justice and DH (PCO000128). At that meeting, Mr Horsley said that while writing to Paul Harris at the Ministry of Justice, he had realised the scale of Operation Rochester. Mr Horsley stated that there were *"extremely serious resource implications for the Coroner, and for the normal operation of the service in his district"* (p2). There was general agreement that the inquests would prove to be a *"crushing expense for the Council"* (p4). In fact, in later correspondence with the Ministry of Justice, Mr Horsley confirmed that at that time he was principally concerned with the potential resource implications of holding up to 92 inquests (PCO000186).

8.11 The record of the August 2007 meeting notes that Mr Horsley also expressed his:

> "… deep misgivings about handling these cases as inquests. The conduct of the doctors concerned was an issue, but so too was the management of the hospital. In his view that aspect went beyond the remit of an inquest. He also had concerns, if the inquest route were taken, about the enormous quantity of evidence and the large number of expert witnesses … He suggested that the public inquiry route would be a better way to address the public expectations. Its terms of reference could be set so as to achieve everything that inquests could." (PCO000128, p3)

8.12 Mr Horsley was not alone in expressing the view that a public inquiry was preferable to an inquest. Karen Murray from Hampshire County Council expressed *"serious concerns. The whole Hampshire budget for the normal Coroner service was some £800,000 and these ten inquests*

would cost at least that. The council would support the best means of exposing the facts, and believed that a public inquiry was the best way to achieve that" (PCO000128, p3). Judith Bernstein from the Ministry of Justice stated that *"the coronial system was not suited to this scope of inquiry"* (p3).

8.13 Colin Phillips, a DH official, said that there would be no public inquiry as the case was *"old and about the actions of individuals"* (PCO000128, p3). It was further pointed out that the deaths at Gosport War Memorial Hospital ('the hospital') did not, in the opinion of DH, *"raise issues of national concern"* (PCO000186). Nor would the Ministry of Justice or DH provide any funding for the inquests if they were to take place (PCO000128, p4).

8.14 Despite DH's refusal to entertain the possibility of a public inquiry, there remained discontent. Mr Bradley wrote to the Ministry of Justice as late as January 2009, just over two months before the inquests touching the ten deaths at the hospital were due to begin, asking for reconsideration of the decision not to hold a public inquiry instead of inquests. He stated that his *"work on the file causes me increasing concern because of the nature of the proceedings"* (PCO000187). The concern expressed went beyond a matter of simple resources to doubts about what could be achieved through the inquest process:

> "… it is quite apparent that inquests are not going to provide any of the families with the answers that they require. The remit of these inquests means that the matters of public policy with which the families are concerned cannot be addressed and taking forward ten cases to inquest means that the remaining eighty two cases that were investigated remain without answers." (PCO000187)

8.15 Mr Bradley went on to say that the:

> "… scope of the inquests will not address the overall provision of health care for the elderly at Gosport … a public inquiry would allow for a full and thorough investigation as a result of which families can maintain confidence in the system for the provision of health care and death certification." (PCO000187, p2)

8.16 Mr Horsley also wrote to the Ministry of Justice in support of Mr Bradley's request for reconsideration of the matter. Mr Bradley said that since the inquests had been opened, *"it has become apparent that the inquest process is not going to deliver the sort of investigations and conclusions which are envisaged by the families involved"*. He added: *"I consider that a public inquiry into all the deaths is needed to allay public concerns about what happened and will do so in a way which the limited scope of the inquest could never do so"* (PCO000186, p2).

8.17 Even the lawyers representing Portsmouth Hospitals NHS Trust ('the Trust') appeared to be of the view that matters should be taken forward by a public inquiry (PCO000636); that the families would not be satisfied by what could be achieved at an inquest (MRE001137); and that the Ministry of Justice had *"fobbed off"* the families by ordering inquests instead of a public inquiry (MRE001098).

8.18 Despite this, the pleas of both Coroners fell on deaf ears. The Ministry of Justice responded that any decision on a public inquiry was a matter for DH. DH remained of the view that *"given the variety of investigations that have already been undertaken and the powers that you have to inquire into all of the circumstances leading up to the deaths, the inquests should now proceed"* (PCO000185).

8.19 The organisation that was perhaps most relieved by the decision not to hold a public inquiry instead of an inquest was the Trust itself. Mr Bradley had indicated in a telephone

call with the Trust's solicitor that he had written to the Ministry of Justice requesting that the hearings should take the form of a public inquiry. The solicitor suggested to Peter Mellor, Company Secretary for the Trust, that a public inquiry would be *"an administrative/PR disaster"* and the NHS would not be happy with one (MRE001037).

8.20 The argument over a public inquiry would return later. At the time, following the meeting on 21 August 2007, the Ministry of Justice sent a letter to the Coroner confirming that DH made it clear *"that the advice of their ministers and the Chief Medical Officer was that a public inquiry was unjustified and that any concerns would be best addressed by the inquest process"* (PCO000057). The Ministry of Justice requested further information in relation to the desirability of opening inquests into the ten deceased before a decision was made to grant Mr Horsley permission to proceed (PCO000057).

8.21 The decision not to hold a public inquiry into the deaths at the hospital was a missed opportunity. As a result, the inquests into the deaths at the hospital were not able to consider in sufficient detail matters relating to the management and history of events at the hospital dating back to 1991, or the culture of proactive prescribing and end of life care more generally.

8.22 Following this decision by DH, both Mr Horsley and Mr Bradley took the view that, if the matter was not to be dealt with by way of a public inquiry, then any investigation would have to be limited in scope.

8.23 The suggestion that the deaths at the hospital did not raise *"matters of national importance"* was surprising.

8.24 Mr Horsley did not respond to the Ministry of Justice request for further information until 26 November 2007 – in part, it appears, because he suffered an injury to his arm (PCO000050). There then followed a further period of nearly three months before the Ministry of Justice made a decision on whether to grant permission for the inquests at all. This was despite two letters from Mr Horsley asking for a decision and highlighting the acute and public embarrassment that the delay was causing (PCO000044).

8.25 Permission was finally provided on 12 February 2008 (PCO000064). Two months later, on 11 April, Mr Bradley and Mr Horsley met to discuss how to proceed with the inquests. It was agreed that Mr Horsley would open the inquests as soon as possible. Mr Bradley was to meet Detective Superintendent (Det Supt) David Williams *"to discuss witnesses, PIPs, timing, time estimate etc and the mechanics for a pre-inquest hearing"*. Mr Bradley was of the opinion that the inquests would require a jury, and he hoped to have a pre-inquest hearing in June with an inquest date in October (PCO000036). The inquests were opened on 14 May 2008.

8.26 The available documents show the arguments which were made in favour of a public inquiry and the reasons given for resisting Mr Horsley's request. The documents show little justification for the delay between the CPS decision in December 2006 and the eventual start of the pre-inquest hearings listed for 14 August 2008.

Why the inquests were limited to ten cases

8.27 On the basis of summaries provided by the police, Mr Horsley quickly formed the view that ten of the Operation Rochester cases would require an inquest. These were the cases that fell into one of the categories considered in the police investigation and described in Chapter 5, namely Category 3B (negligent treatment where the cause of death was unclear). However, little, if any, consideration appears to have been given in the early stages of the Coroner's involvement to the possibility that some of the other cases assessed by the Key Clinical Team

(KCT) may have required an inquest. The KCT, headed by Professor Robert Forrest, Professor of Forensic Toxicology at the University of Sheffield, had been instructed by the police to consider the evidence in relation to the 91 deaths investigated as part of Operation Rochester.

8.28 The information provided to Mr Horsley in updates from the police was that the Category 2 cases were *"considered to be sub optimal (care) but did not present evidence of unlawful criminal activity"* (PCO000081, p1). The file of material the police provided to Mr Horsley on 11 April 2007 only contained evidence in relation to the ten Category 3B cases. It also contained an *"Investigation Overview"* of Operation Rochester prepared by Det Supt Williams. The overview document referred to the fact that during the third investigation:

> "… initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns … Professor Richard Baker during his statistical review of mortality rates at the hospital identified 16 cases which were of concern to him in respect of pain management … 14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006 … [and] a total of 92[2] cases were investigated by the police during this third phase of the investigation." (PCO000296, p6)

8.29 The Panel notes that the test for whether a case should be the subject of criminal prosecution is significantly different from the test for whether it should be the subject of an inquest by a Coroner. A Coroner is required to hold an inquest in cases where he/she has reasonable grounds to suspect that the deceased has died a violent or unnatural death or has died a sudden death of which the cause is unknown. A death that the police consider does not involve evidence of 'unlawful criminal activity' or 'negligence' by the treating clinician could still necessitate an inquest by the Coroner.

8.30 Of the 57 cases that the KCT considered fell into Category 2, 20 were categorised as being 2B (sub-optimal care where the causes of death are unclear). One case was categorised as 1B (optimal care where the cause of death is unclear). In a number of the Category 2 cases, the KCT was unable to provide any opinion on the cause of death because of the paucity of medical records (HCO001601). For further explanation of how the KCT operated, please see the Key Clinical Team Table on the Gosport Independent Panel website (https://gosportpanel.independent.gov.uk/kct).

8.31 On 7 June 2007, Susan Rolling of Hampshire Constabulary asked Mr Horsley how many inquests there would be. He responded as follows:

> "The simple answer is that I don't yet know yet … I'm only intending to do inquests on this limited list [i.e. ten] not the remainder of the 92 because at the moment I have no evidence before me that gives me reasonable cause to suspect that their deaths are anything other than natural." (PCO000065)

8.32 The Panel notes that Mr Horsley appears to have taken a restrictive view of his duty in this regard.

8.33 A letter to the Ministry of Justice dated 15 June 2007 discloses the extent to which the Coroner was relying on the view taken by the police. Mr Horsley explained that:

2 The actual figure is 91 cases. Two different patients with the same name were on the Operation Rochester list, but only one of those patients had been treated at Gosport War Memorial Hospital.

> "… given the fact that the police investigated 92 deaths, hundreds of witnesses were interviewed and their statements run into many thousands of pages. For obvious reasons, I have not read in detail the totality of the evidence gathered but from my understanding of it and my discussions with the police officers involved in the investigations I take the view that in respect of the ten deaths … I am under a duty to hold Inquests into their deaths." (PCO000058, p2)

8.34 In support of the proposition that the inquests should proceed by way of a public inquiry, Mr Horsley repeatedly referred to the fact that further inquests might well need to be carried out, in addition to inquests for the ten deceased who had been identified as Category 3 cases. At the meeting with the Ministry of Justice on 21 August 2007, Mr Horsley said that *"while 82 of the 92 did not pass the test for criminal investigation, many more deaths than the remaining 10 might well warrant an inquest, with its lower evidential hurdle"* (PCO000128, p2). He went on to say that he thought it *"dangerous"* only to consider the ten cases, as *"other families would call for inquests and he could not see how to resist. There would be judicial review cases against him"* (p3).

8.35 Further, in a letter dated 26 November, Mr Horsley stated:

> "… the opening of inquests into these ten deaths may well give rise to calls from the relatives of the other 82 persons whose deaths were investigated as part of Operation Rochester. None of the 92 deaths investigated by the police were ever reported to the Coroner at the time of the deaths. **All had elements to them suggesting that the circumstances of the deaths might not be entirely natural**" (our emphasis). (PCO000050)

The Panel is reminded of the test by which a Coroner is under a duty to hold an inquest: "*if there are reasonable grounds to suspect that the deceased (a) has died a violent or unnatural death or (b) has died a sudden death of which the cause is unknown*" (section 8(1) of the Coroners Act 1988). It is not clear from the documents what, if any, further consideration was given to whether inquests should be held into the other 81 deaths that had been investigated as part of Operation Rochester.

8.36 Following the opening of the ten inquests in May 2008, letters were sent to the Coroner's Office enquiring whether there would be any further inquests. One such enquiry came from the legal representatives of Gillian Mackenzie, who enquired whether Mrs Mackenzie's mother, Mrs Richards, was going to be the subject of an inquest (BLC003749). Mr Horsley's initial response to Det Supt Williams was that *"my understanding of the evidence presented to me as a result of Operation Rochester is that Mrs Richards' death could not be ascribed to anything other than natural causes"* (PCO000243, p2).

8.37 As the inquest that was eventually held into the death of Mrs Richards showed, this initial assessment was wrong and demonstrates the very limited extent of the information that Mr Horsley was given in relation to the other 81 deaths that had been investigated as part of Operation Rochester. In the case of Mrs Richards, Mr Horsley had to ask for comments from the police in relation to criticisms raised in a letter received from Bindmans LLP, the solicitors then acting for Mrs Mackenzie. When the police eventually responded, in October 2008, they noted that Professor David Black, a consultant in geriatric medicine, had concluded that the dose of diamorphine given to Mrs Richards was sub-optimally high but that *"he did not believe this contributed in any significant way to Mrs Richards death and that her death was by natural causes"* (PCO000212, p2). Nevertheless, Mr Horsley did proceed to hold an inquest into

Mrs Richards' death as, when the police provided him with further information, it transpired that her death would have been reported under his reporting criteria.

8.38 The police appear to have provided Mr Horsley and Mr Bradley with very limited information in relation to the other 81 cases. The approach of the Coroner's Office was that there would be no enquiry by the Coroners beyond the ten deceased who had been identified as Category 3B cases. At the first pre-inquest hearing on 14 August 2008, it was indicated to the Coroner that six other families had said they were concerned about their relatives who had been patients at the hospital and had subsequently died. Mr Bradley was provided with the details of the family members concerned, but the Coroner was not pressed to make a decision as to whether their cases should be included within the inquest hearings that had been listed.

8.39 The note of the pre-inquest hearing on 14 August 2008 records the Assistant Deputy Coroner Mr Bradley, who conducted the hearing, as stating that the decision in respect of the ten deceased people included in the inquest was that of the Secretary of State, and not his decision (PCO000736, p2).

8.40 On the basis of the papers that the Panel has seen, it appears that the Coroner and Assistant Deputy Coroner were given very little information by the police in relation to the other 81 deaths, but no effort appears to have been made to make any further enquiries in relation to those deaths.

The inquests: 21 days of evidence

8.41 Day one of the inquest hearings was 18 March 2009. The Panel notes that this was over two years after the Coroner took a provisional view in relation to the requirement for him to hold inquests into the ten deaths.

8.42 The hearings ran for 21 days (CPS000047). In total, 21 witnesses gave live evidence and 29 witness statements were read to the jury. The Coroner heard evidence from family members of the deceased patients, clinicians and nurses involved in their treatment at the hospital, and experts who had been instructed to consider the causes of the individual deaths.

8.43 When it was thought that the inquests would engage Article 2 of the Human Rights Act, the Coroner had proposed a format whereby the inquests would involve generic evidence being called, followed by evidence in relation to the individual deaths (HCO002440). Originally it was thought that the inquests would last between four and six weeks (PCO000736, p1) and the generic evidence would last two weeks (AMA000053). However, by the time of the second pre-inquest hearing in January 2009, and following discussions with the solicitor for the Trust, Mr Bradley had decided that Article 2 was not engaged. As a result, the format of the inquests changed significantly. At the pre-inquest hearing in January 2009, Mr Bradley determined that he would hold ten individual inquests and, while there would be some generic evidence heard in them (MRE000981, p1), this was likely to come from Professor Black, Dr Andrew Wilcock and Dr Barton (BLC001839, p2).

8.44 The Coroner allowed the scope of the inquests, and the evidence that the witnesses gave, to extend beyond examining only the medical cause of death of each of the ten deceased. Individual witnesses gave generic evidence relating to the administration of drugs through syringe drivers and the practice of anticipatory prescribing at the hospital (CPS000006, pp22–50). Evidence was also heard in relation to the poor record keeping by both Dr Barton and the nurses working at the hospital (CPS000004, p11). Dr Barton gave evidence relating

to the difficult conditions she was working under. She described having too much to do at the hospital and too little time in which to do it (CPS000019, p24). The inquests also heard evidence in relation to the supervision of both Dr Barton and the nurses, and the involvement of the consultants in the day-to-day operation of the wards at the hospital.

8.45 The evidence touched upon certain issues relating to the administration of the hospital, such as pressures on bed numbers and the suggestion that some patients were transferred from surgical wards to Dryad Ward too soon (CPS000008, pp30–68). Nobody involved in the management of the hospital or any senior administrator gave evidence at the inquests.

8.46 Mr Tom Leeper, Counsel for four of the families, wanted to explore the issue of the nurses' concerns expressed in 1991. The Coroner determined that *"If it is a question of there had been concerns in the past, I think that has got to be right; I would admit that. If we are talking specifically about meetings and other people who have died, I very specifically don't want to do that"* (CPS000010, p9). Mr Leeper explained that he wanted to explore the concerns that had been raised rather than any other deaths, but that non-compliance with the analgesic ladder in 1991 was of *"central relevance"* to the question of whether, when it was not complied with in 1998 and 1999 (p10), there might be evidence of gross negligence manslaughter. Despite objections from Counsel for Dr Barton and the Nursing and Midwifery Council, the Coroner allowed Mr Leeper to question Staff Nurse Anita Tubbritt on the subject of the 1991 concerns. Staff Nurse Tubbritt gave evidence that in 1991 there were concerns that the analgesic ladder guideline was not being complied with in relation to the administration of analgesia. There were also concerns about the amount of training the nurses had received, and the fact that syringe drivers were relatively new on the ward. Her evidence was that these concerns had already been addressed by 1996 (CPS000010, pp21–9). Nurse Beverley Turnbull gave evidence that there had been concerns raised in 1991 relating to the use of syringe drivers, but that these had been resolved by 1996/97 (CPS000019, pp4–29).

8.47 Dr Barton gave evidence over the course of three days, although not continuously. Prior to Dr Barton's evidence, Mr Bradley had told her that she was not obliged to answer any questions *"if they are going to compromise you in any future proceedings"* (CPS000016, p22). Nevertheless, Dr Barton answered all the questions that were put to her.

8.48 Professor Black and Dr Wilcock gave expert evidence over the course of two days each. Both gave generic evidence on the use of drugs, and in particular opioids, in palliative care and end of life care (CPS000012, CPS000014, CPS000029, CPS000031). Both also gave evidence on the practice of anticipatory prescribing and the involvement of consultants in district hospitals. Dr Wilcock was asked to comment on the practice of having a GP acting as the clinical assistant for the ward. He said that it was something he had not come across before and that time constraints would be evident (CPS000029, pp15–16).

8.49 Professor Black and Dr Wilcock acknowledged in their evidence that they were hampered by the fact that they had not seen the patients before they died and so were reliant on the medical records that had been created at the time. It was recognised that such notes were often lacking in detail and that this created a problem for both experts in determining precisely what had happened (CPS000012, pp4–79; CPS000029, pp4–9).

8.50 Both experts were able to give causes of death but disagreed on a number of the ten cases. While neither expert gave as the cause of death any form of drug overdose caused by the administration of drugs at the hospital, in a number of cases Professor Black raised concerns about the administration of drugs as follows:

- In respect of Leslie Pittock, the starting doses of diamorphine in the syringe driver were higher than he would normally have expected (CPS000012, p7).
- In respect of Elsie Lavender, the dose of diamorphine that she was given was *"significantly higher"* than the conventional dose, and he could not explain why it had been chosen. Professor Black went on to state: *"I obviously cannot say that that dose of diamorphine might not have slightly hastened death"* (CPS000012, p40).
- In respect of Ruby Lake, he could not understand the need for a syringe driver at all (CPS000012, p43).
- In respect of Helena Service, he would have started her on a lower dosage of diamorphine than she was given, but said that he found it *"difficult to criticise 20mg without having been in a position to actually examine her"* (CPS000012, p48).
- In respect of Arthur Cunningham, he could find no explanation or justification for the increases in the dosages of midazolam and diamorphine given, and concluded that it was *"possible"* that Mr Cunningham's life had been shortened by the doses of drugs given (CPS000012, pp72–3).
- In respect of Geoffrey Packman, he found no explanation for the jumps in the dosage of diamorphine that was given, and said that it was *"possible"* that the dose was excessive (CPS000014, p15).
- In respect of Elsie Devine, he was not clear why a fentanyl patch was started as it was an unusual drug to start with (CPS000014, p22). Professor Black also agreed with the proposition that there had been a *"substantial overdose"* from the combined effect of the administration of diamorphine and the morphine from the fentanyl patch (p30).
- In respect of Robert Wilson, he could find *"no clear justification"* for the use of morphine oral solution, and stated that the dose of analgesia *"formed a major contribution to the clinical deterioration that occurred over 15 and 16 October … [which] more than minimally contributed to the death of Mr Wilson"* (CPS000014, p71).
- In respect of Enid Spurgin, he could find no reason why her dosage of analgesia was increased (CPS000014, p79).

8.51 In commenting on his own evidence when questioned about the residual effects of fentanyl, Professor Black said: *"I am not an expert, I will say now in the pharmacodynamics of drugs and I think you need further advice on that I would get it from an expert on pharmacodynamics"* (CPS000014, p23 D). When questioned about the effects of a concentration of drugs in the body, Professor Black said: *"I am certain that a pharmacologist expert would be able to do that for you"* (p51 E).

8.52 Dr Wilcock also gave evidence criticising the administration of drugs in a number of cases in the following terms:

- In respect of Mr Pittock, doses of diamorphine were administered that were excessive to his requirements (CPS000029, p5 A). Whether the dosage of diamorphine had a negative impact was difficult to judge, but if it did, it led to a shortening of Mr Pittock's life by a matter of hours or a small number of days (p5 B).
- Mrs Lavender was prescribed doses of diamorphine and midazolam that were excessive for her needs (CPS000029, p13 D).
- Mrs Service was not given thioridazine, a drug previously prescribed at Queen Alexandra Hospital to help settle her at night: *"it seems at odds [to me] that the response to that was to start Midazolam 20mgs in a syringe driver"* (CPS000029, p19 E).

- Mr Cunningham had been prescribed a large dose of diamorphine that was excessive to his needs, and it was hard to know how to justify the increased dosage used in the syringe driver (CPS000029, p29).
- Mrs Spurgin had been commenced on a syringe driver of diamorphine and midazolam that was likely to have been excessive for her needs, and the doses of diamorphine and midazolam would have contributed more than minimally to her death (CPS000029, p43).
- The inappropriate management of Mr Packman's gastrointestinal haemorrhage, together with his exposure to unjustified and inappropriate doses of diamorphine and midazolam, contributed more than minimally or negligibly to his death (CPS000029, pp48–9).
- In respect of Sheila Gregory, in the absence of a thorough medical assessment it was unclear if the use of opioids was justified (CPS000029, p70).
- In respect of Mrs Devine, the fentanyl patch that was used far exceeded the recommended dose for a frail woman and there was no justifiable reason for its use (CPS000031, p17). However, Dr Wilcock also said that it would have been difficult to separate out the impact it would have had on her situation.
- In respect of Mr Wilson, the doses of morphine oral solution that were administered were four times higher than recommended and could not be justified. Dr Wilcock did not consider the pre-emptive prescription of diamorphine, hyoscine and midazolam to be appropriate. However, in his view it was difficult to say with any degree of certainty that the doses of oral morphine or diamorphine that Mr Wilson received had contributed more than negligibly to his death (CPS000031, p38).

8.53 The jury also heard written evidence from a range of experts. These were Dr Michael Petch, a cardiologist, in respect of Mr Pittock (CPS000010, p36); Dr Christopher Dudley, a nephrologist, in respect of Mrs Devine (CPS000223, pp52–3; CPS000031, pp4–6, pp31–7); and Professor Richard Baker in respect of Mr Wilson. Professor Baker gave his opinion that Mr Wilson might have left hospital alive if he had not been started on opioids (CPS000023, p12).

8.54 On the first day of the hearing, Mr Leeper invited the Coroner to call Professor Gary Ford, a professor of pharmacology at Newcastle University, as a witness concerning the death of Mr Cunningham. However, despite having knowledge of the extent of Professor Ford's potential to assist, the Coroner refused to allow him to give evidence, or his evidence to be read, on the basis that he was covering the same ground as Dr Wilcock and Professor Black (CPS000004, p27).

8.55 Concern was raised during the inquests as to what evidence had been given to the experts prior to them writing their reports. For example, Dr Wilcock had not seen the witness statement from Mr Wilson's son, in which he described his father as being drowsy after he was prescribed morphine oral solution (CPS000031, p66). Also, Dr Dudley was not given all the medical records but was instead provided with Dr Barton's written witness statement and an incorrect summary from the police (p31).

8.56 Following the conclusion of the evidence, the Coroner invited submissions as to which verdicts should be left to the jury.

8.57 Mr Leeper invited the Coroner to leave open to the jury a verdict of unlawful killing in respect of Mr Cunningham, Mr Packman and Mrs Devine on the basis of gross negligence by Dr Barton (PCO000841, PCO000842, PCO000844). Patrick Sadd, Counsel for the Wilson family, also asked for unlawful killing to be left to the jury in respect of Mr Wilson (PCO000848). The

Coroner rejected these submissions on the basis that there was not before the jury evidence of unlawful killing to satisfy the standard of proof required; that is, beyond reasonable doubt. The Coroner also noted that the issue of causation could not be satisfied and that the jury did not have evidence of one cause of death that was suggestive of drug overdose. The evidence of all the experts suggested natural causes of death (CPS000039, p45).

8.58 Both Mr Leeper and Mr Sadd raised the issue of 'missing' evidence. Mr Leeper stated that the Coroner had raised the issue of the absence of evidence in relation to opioid toxicity: *"[if] … there is a lacuna in the evidence which has been given, that is something which could easily be remedied by calling an appropriate expert and if … sir feels that there is a lacuna … sir is under a duty to do so"*. In the event, the Coroner refused to adjourn the inquests to obtain such evidence (CPS000039, p17).

8.59 The Coroner also refused to leave available to the jury the possibility of verdicts of neglect or an open verdict, telling the jury that an open verdict *"is not going to help anyone"* (CPS000039, p16).

8.60 At an early stage of the inquests, the Coroner had indicated that he was considering obtaining narrative verdicts from the jury by asking them to answer a series of questions (CPS000010, pp42–3). On Day 15 of the hearings, the Coroner gave an indication of the type of issues that he wanted the jury to deal with:

> "I think the areas of concern are the clinical regime at Gosport. I think that has got to be a concern to me and to the jury. The degree of supervision; the fact that it is a GP unit I think may have affected the regime in the hospital – the input of the consultants – I wonder if that was sufficient and whether there was enough involvement? … I think the question of appropriate opioids, whether the dosage was appropriate, whether the medication … played a material part in death … It seems fairly significant, being perhaps the most significant factor for the jury." (CPS000035, p82)

8.61 Various interested parties to the inquest raised objections to the Coroner inviting the jury to answer questions in relation to much of the clinical regime at the hospital, on the basis that the inquests were not being conducted under Article 2. Inviting the jury to make determinations on such matters would be beyond the lawful scope of the inquests (PCO000849, CPS000039, p44). Ultimately the Coroner did not frame any questions for the jury on these matters, stating that he felt this was a *"separate issue and that is something that the Government chose not to do"* (CPS000039, p44).

8.62 The Panel presumes that this is a reference to the decision not to hold a public inquiry into the events at the hospital. The Panel notes that, had the inquests been conducted under Article 2 (which, if they were held today, they almost certainly would be), answers to these questions could well have formed part of the jury's narrative verdict.

8.63 The Coroner did, however, leave questions to be answered by the jury in relation to the administration of medication: specifically, whether that medication more than minimally or negligibly contributed to the patients' deaths, and whether it was given appropriately. Both Counsel who represented family members had made submissions suggesting that the Coroner should set out questions for the jury in a narrative verdict on these matters (PCO000841, PCO000842, PCO000844, PCO000848).

8.64 In an oral submission, Mr Leeper said:

> "It seems that the advantage of a narrative verdict which deals with the specific questions that we have set out would be to bring out those facts of the case clearly. It would enable the jury to express a conclusion on the key factual issues in the case." (CPS000039, p24)

8.65 The documents show the Coroner's opinion on those verdicts that would have reflected the families' concerns: *"trite Home office category verdicts are not going to answer people's questions. You can walk away with an open verdict, you can walk away with unlawful killing, but it actually does not answer the questions that people want to have answered"* (CPS000039, p24).

8.66 The Coroner proposed another question for the jury: whether the medication was given for a therapeutic purpose (CPS000039, p46). The documents give no indication as to the origin of this question; nor are there any signs of objection to its inclusion.

The verdicts

8.67 The jury was tasked with determining the cause of death of each of the deceased and answering the following questions in relation to each of them:

> "1. Did the administration of any medication contribute more than minimally or negligibly to the death of the deceased?
>
> If yes:
>
> 2. Was that medication given for therapeutic purposes?
>
> If yes:
>
> 3. Was that medication appropriate for the condition or symptoms from which the deceased was suffering?" (PCO000979)

8.68 The jury deliberated for two days and, having received a majority direction, returned the following verdicts:

> "**Pittock –** Cause of death 1a. bronchial pneumonia 2 severe depression.
>
> Did the administration of medication contribute more than minimally/negligibly to death? NO
>
> **Lavender** – Cause of death 1a. high cervical cord injury.
>
> Did the administration of medication contribute more than minimally/negligibly to death? YES
>
> Was the medication given for therapeutic purposes? YES
>
> Was medication given appropriately for condition/symptoms? YES

Service – Cause of death 1a. Congestive Heart Failure.

Did the administration of medication contribute more than minimally/negligibly to death? NO

Lake – Cause of death 1a. bronchial pneumonia 2. Fractured neck of femur repaired 5.8.99

Did the administration of medication contribute more than minimally/negligibly to death? NO

Cunningham – Cause of death 1a. bronchial pneumonia 1b. sacral ulcer. 2. Parkinson's Disease.

Did the administration of medication contribute more than minimally/negligibly to death? YES

Was the medication given for therapeutic purposes? YES

Was medication given appropriately for condition/symptoms? YES

Wilson – Cause of death 1a. congestive cardiac failure 2. Alcoholic cirrhosis

Did the administration of medication contribute more than minimally/negligibly to death? YES

Was the medication given for therapeutic purposes? YES

Was medication given appropriately for condition/symptoms? NO

Spurgin – Cause of death 1a. infected wound 1b. fractured right hip repaired 20.03.99

Did the administration of medication contribute more than minimally/negligibly to death? NO

Packman – Cause of death 1a. gastrointestinal hemorrhage.

Did the administration of medication contribute more than minimally/negligibly to death? YES

Was the medication given for therapeutic purposes? YES

Was medication given appropriately for condition/symptoms? NO

Devine – Cause of death 1a. chronic renal failure 1b. ameloidosis 1c. IgA paraproteinaemia.

Did the administration of medication contribute more than minimally/negligibly to death? YES

Was the medication given for therapeutic purposes? YES

Was medication given appropriately for condition/symptoms? NO

> **Gregory** – Cause of death 1a. pulmonary embolism 2. Fractured neck of femur.
>
> Did the administration of medication contribute more than minimally/negligibly to death? NO." (CPS000047)

8.69 Some of the family members publicly expressed their disappointment that the reports of five medical experts (Professor Ford, Professor Black, Dr Wilcock, Professor Baker and Professor Forrest) had not been put before the jury. Charles Stewart-Farthing, Mr Cunningham's stepson, described the inquests as being *"biased towards the medical profession"* and said that *"the whole thing has been a total waste of public money"* (FAM000676, p1). In an email to Mr Sadd, Iain Wilson, Mr Wilson's son, said of the verdict that *"it might not have been what I originally hoped for, but it was certainly more than I expected"*. However, he was *"not happy with the outcome"* (BLC001007, p1). Pauline Gregory, Mrs Gregory's granddaughter, expressed her view that *"the verdicts are a sham. It appears the only families who got a yes verdict are the loud ones who turned up every day clutching a briefcase"* (BLC001009, p1).

8.70 The families called for a fresh police investigation so that criminal charges could be brought against those responsible, but Hampshire Constabulary indicated that they had no such plans (FAM002241).

8.71 Action Against Medical Accidents, a charity which had had close involvement with some of the families throughout, issued a press release stating that the verdicts *"failed to satisfy the families involved … It is now quite clear that Jack Straws refusal to hold a public inquiry was wrong"* (AMA100078). After the verdicts, DH maintained the position that a public inquiry should not take place. Prior to making a final decision, it said that it would await the outcome of the GMC hearing and the inquest into the death of Mrs Richards (DOH006249, p3).

8.72 Dr Barton released a statement through the Medical Defence Union saying that she was *"pleased that the jury recognise that in all of these cases drugs were only given for therapeutic purposes"*. Dr Barton's husband was quoted as saying that *"We're delighted to know that they are for natural causes in all 10 cases and that the opiates were given in all 10 cases, for therapeutic reasons"* (FAM000630, p2).

8.73 The Trust also sought to focus on the issue of the jury's answers to the question of 'therapeutic purposes'.

8.74 While expressing sympathy for the families, the press release issued by the Trust stated:

> "It is important for everyone involved in the care of these patients that five verdicts indicate that the medication used to treat and relieve their symptoms did not contribute to their deaths. In two verdicts, whilst contributing to death, medication was appropriately given. It is a matter of regret to the NHS that three verdicts indicate that in the mid/late 1990s the medication administered to these patients has been found to have contributed to their deaths. However, in those cases it was found to have been given for therapeutic purposes … apologise to families concerned … the systems and policies in place at Gosport War Memorial Hospital have undergone a complete overhaul … issues highlighted … have been addressed and the care at Gosport War Memorial Hospital today is of the highest standard." (DOH700627, p1)

8.75 The Panel is not surprised that the documents reflect the disappointment of the families with the outcome of the inquests.

The inquest into the death of Gladys Richards

8.76 In a telephone conversation with Mrs Mackenzie on 23 May 2008, Mr Horsley said that inquests were only going to be carried out into the ten deaths identified and that he was not intending to hold inquests for any of the others, including her mother, Mrs Richards (PCO000786, p2). Mrs Richards was not one of the Category 3 cases referred to the Coroner by the police following the conclusion of Operation Rochester. In fact, Mrs Richards fell into Category 2A – 'sub-optimal but died of natural causes' (PCO001667).

8.77 On 22 July 2008, Bindmans LLP, the solicitors representing Mrs Mackenzie, wrote to Mr Horsley and requested that he hold an inquest into the death of Mrs Richards (PCO000255). On 11 August, Mr Horsley passed this letter on to Det Supt Williams, stating:

> "From my understanding of the evidence presented to me as a result of Operation Rochester is that Mrs Richards' death could not be ascribed to anything other than natural causes. This view coincided with that of the police and CPS in not including her death in the ten cases where criminal proceedings were contemplated. Hence, I decided not to open an inquest on her death." (PCO000243, p2)

8.78 It would be 10 October before Hampshire Constabulary responded to the issues raised three months earlier. In doing so, Det Supt Williams provided extracts from Dr Black's statement. Dr Black had said:

> "In particular, I am concerned about the anticipatory prescription of opioid analgesia on her admission to Gosport War Memorial Hospital. If no justification for this can be identified or proven, then I believe that this was negligent practice and may have contributed to her fall on the ward. I also believe that the dose of diamorphine, in particular prescribed on the 17th August, was sub optimally high. However, I do not believe this contributed in any significant way to Mrs Richards death and that her death was by natural causes." (PCO000212, p2)

8.79 It was only after receiving this letter that Mr Horsley asked whether Mrs Richards had been buried or cremated. This was relevant because if Mrs Richards had been cremated – as she had been – the Coroner would need to seek the Secretary of State's permission, through the Ministry of Justice, to hold an inquest. When Mr Horsley sought such permission, five weeks after receiving the letter from the police, he signalled his *"intention to open Mrs Richards inquest at the earliest opportunity and to have it heard as part of the series of Gosport War Memorial Hospital inquests which are scheduled to be held in March 2009"* (PCO000204).

8.80 The delay in considering and responding to the Coroner's request effectively derailed his plan to hold this inquest along with the other ten.

8.81 The response from the Ministry of Justice to Mr Horsley's request was painstakingly slow. On 10 December 2008, a submission was made to Bridget Prentice (a Minister at the Ministry of Justice) recommending that authority should be granted for opening an inquest into the death of Mrs Richards (MOJ000088). Mr Horsley felt compelled to write to the Ministry of Justice again in January 2009 asking if a decision had been made in relation to the case of Mrs Richards: *"time is now very short for Mrs Richards' relatives – and my deputy who is conducting these inquests on my behalf – to prepare for an inquest into Mrs Richards' death, if such an inquest is to take place in sequence with the other inquests"* (PCO000188, p1). Mr Horsley again asked that Ministry of Justice staff stress the reasons why a prompt decision was necessary to the Minister

(PCO000184). However, Mr Horsley was not sent permission to hold the inquest until 28 January 2009, over two months after the request had been made and its urgency flagged (PCO000174).

8.82 The documents seen by the Panel show that there was little justification for this delay, and that important consequences flowed from it. The delay meant that the approach favoured by Mr Bradley, to hold Mrs Richards' inquest separately from the other ten, prevailed. Mr Bradley sought to justify his view by suggesting that *"the circumstances and issues surrounding [Gladys Richards'] death are different from the other deaths in Gosport War Memorial Hospital".* It was also stated that the opening of the inquest would not take place in an open court and that the inquest would not be heard with a jury (PCO000171, p1). Mrs Mackenzie wrote back to Mr Horsley expressing her surprise that her mother's inquest was to be heard separately and without a jury (PCO000571, p2). Mr Horsley passed Mrs Mackenzie's letter to Mr Bradley and asked him *"to reconsider the situation whilst there's still time to tack this one on with the others"* (PCO000571, p1). Mr Bradley said:

> "… thanks but no thanks … I cannot take this on without jeopardising the progress of the other ten inquests. I have had two pre-inquest hearings for those. There are three lever arch files of advanced disclosure and the reason for assumption of jurisdiction is completely different." (PCO000163, p1)

8.83 The documents show little justification for the decision to hold the inquest into the death of Mrs Richards separately. The 11 cases, as they would have been, had many of the same features. Mr Horsley opened Mrs Richards' inquest on the first of the substantive hearing days in the ten other inquests. But it opened in private; and there is no basis for doing this in the documents reviewed by the Panel.

8.84 The Panel has considered the documentation relating to the period of over four years between the opening of the inquest and the first day of evidence in Mrs Richards' case. On 15 September 2009, Alex Marshall, Chief Constable of Hampshire Constabulary, wrote to Mr Horsley saying:

> "Hampshire Constabulary and the Crown Prosecution Service intend to review the transcripts of both the GMC hearings and the evidence given under oath at your inquests held during March of this year to ascertain whether there is new information suitable for investigation or the commencement of criminal proceedings." (PCO002299, p2)

As a result of this letter, Mr Horsley suspended his investigation pending the outcome of the review that the CPS and police were going to conduct (PCO002131).

8.85 The documents show that there was a period of 11 months between Ch Const Marshall's letter and the decision not to prosecute in the case of Mrs Richards, which was conveyed on 16 August 2010 (PCO002291). However, the documents show no justification for the further delay. It was not until 7 April 2011 that Mr Horsley wrote to Blake Lapthorn, solicitors for some of the families, and Mills & Reeve LLP, solicitors for the Trust, to inform them that he was in possession of sufficient evidence to hold an inquest into Mrs Richards' death (PCO002107, p1; PCO002175, p1). The hearings in the substantive inquest would not begin until 9 April 2013 (PCO001583).

8.86 The inquest took place before Mr Horsley and lasted for nine days. Ten witnesses gave evidence in person and three had their statements read out (PCO001877). Mrs Mackenzie

and Lesley O'Brien gave evidence in relation to their mother's treatment, as did a number of clinicians and nursing staff involved in the treatment of Mrs Richards (PCO001858, pp1–11).

8.87 While the Coroner had determined that the inquest into the death of Mrs Richards did not engage Article 2 of the Human Rights Act, various witnesses gave evidence that went beyond simply the question as to by what means she died. Evidence was admitted in relation to the working conditions at the hospital and the fact that Dr Barton and the staff struggled to cope with the levels of work they had to deal with (PCO001858, p12). Nurse Philip Beed, Clinical Manager, stated that the families of patients being admitted to the ward had unrealistic expectations and that their hopes in relation to what could be done often could not be met because of the condition of the patients (pp21–31). Dr Richard Ian Reid, a consultant at the hospital, gave evidence in relation to anticipatory prescribing and the involvement of the consultants (p12).

8.88 Dr Barton gave evidence over the course of two days at the inquest. She accepted that the standard of her note keeping was poor, that she had had little time to spend with patients, and that there had been a change in practice at the ward after she resigned (PCO001858, p41).

8.89 Both Professor Robin Ferner and Professor Black gave expert evidence. Professor Ferner's opinion was that it was *"likely"* that the subcutaneous administration of diamorphine (that is, by syringe driver) had hastened Mrs Richards' death. Sedation could lead to the inability to swallow, which in turn could lead to kidney failure (PCO001859, pp9–11). Professor Black considered Mrs Richards' death to be due to a more complex set of circumstances. Factors that had played a part included her age, frailty and end stage dementia, taken together with the trauma sustained as a result of falls and corrective surgery. Professor Black agreed that the analgesics and sedatives had also made a contribution to her death (p11).

8.90 James Mehigan, Counsel instructed on behalf of Mrs Mackenzie, made submissions inviting the Coroner to consider a narrative verdict incorporating the following questions: whether the management of Mrs Richards' medical condition at the hospital was appropriate; whether the administration and dosage of painkilling and sedative drugs was appropriate; and, if the answer to either of those questions was 'no', whether such inappropriate actions caused or contributed more than minimally, negligibly or trivially to Mrs Richards' death. The Coroner was also invited to consider a verdict of unlawful killing or, as an alternative, a verdict of neglect (PCO001662).

8.91 On 17 April 2013, Mr Horsley returned a narrative verdict in the following terms:

> "1. Gladys Mabel Richards died at Gosport War Memorial Hospital at 21:20 hours on 21st August 1998.
>
> 2. Mrs Richards' death was due to bronchopneumonia; factors contributing more than insignificantly to her death from bronchopneumonia were: -
>
> - Accidental falls which she sustained at Glen Heathers Nursing Home, Lee on the Solent, on the 29th July 1998 and at the Gosport War Memorial Hospital on the 13th August 1998.
>
> - Procedures undertaken at Haslar Hospital, Gosport, to treat the injuries she suffered as a result of those falls.
>
> - Her immobility subsequent to those procedures.

- Medication administered to her at Gosport War Memorial Hospital for the control of her pain and agitation.
- Her old age, frailty and end stage dementia." (PCO001582)

8.92 Following the Coroner's verdict, Mrs O'Brien stated that she was *"disappointed after all of this time"* by the verdict (SOH100666, p1). Mrs Mackenzie also criticised the verdict, saying that it was *"extraordinary"* that the Coroner found her mother to be in the end stages of dementia (FAM001101). John White of Blake Lapthorn, who represented Mrs Mackenzie, expressed the view that the outcome was *"weakly positive"* and that while it was *"fundamental to be able to show that the prescribing was a significant contributory cause of death"* – which Mr Horsley *"did find ... on the balance of probabilities"* – Mr White was disappointed *"… that [Mr Horsley] did not feel able to venture any criticisms of Dr Barton and the nurses"* (FAM101480, p1).

8.93 Julia Barton, Chief Quality Control Officer at the Fareham and Gosport Clinical Commissioning Group, offered her sympathies to Mrs Richards' family and said that *"any necessary action"* would be taken following a review of the verdict, but *"that lots had changed at the hospital since the late 1990s"* (FAM001101, p1).

Issues raised in the conduct of the inquests

8.94 As the introduction to this chapter suggests, the documents highlight a number of issues with the conduct of the inquests.

Legal representation of families and associated funding

8.95 In the case of the inquests into the ten deaths at the hospital, Blake Lapthorn solicitors were approached by Action Against Medical Accidents to represent clients at the inquests, initially on a pro bono basis with a view to obtaining *"exceptional funding"* from the Legal Services Commission (LSC) (BLC000657, p1). Harriet Jerram, Counsel, was also instructed to act on a pro bono basis. The Coroner was made aware that both the solicitors and Counsel were acting on a pro bono basis but that an application for exceptional funding was going to be made (BLC000648, p5(28)).

8.96 There were clear difficulties in obtaining funding for the representation of the families at the inquests.

8.97 Blake Lapthorn solicitors sought the support of the Coroner in their application for funding (PCO000175, p1). Mr Bradley did write to the LSC in support of the application for funding, stating that *"from my point of view the more families that are represented the more effective these inquests will be"* (PCO000612).

8.98 Following Mr Bradley's letter to the LSC, Blake Lapthorn solicitors sent a further letter to the LSC requesting that funding be provided to allow them to represent the families of four of the deceased (Mr Packman, Mrs Gregory, Mrs Devine and Mr Cunningham) (BLC000449). However, on 3 March 2009, the solicitors felt compelled to write to Mr Bradley again (PCO000161). The LSC had made a recommendation to the Ministry of Justice that funding be granted, but it was not clear whether the Ministry would accept this recommendation. This situation created difficulties for Harriet Jerram, as she was acting pro bono and could not attend the hearings every day. Mr Bradley subsequently wrote to the LSC expressing his *"concern"* that the matter had not been resolved (PCO000559).

8.99 The Panel notes that a decision in respect of funding was not made until 10.00am on 18 March 2009, the day that the inquests began (PCO001032, p1).

8.100 The delay in the decision to grant funding to the families' lawyers caused enormous difficulties for both Blake Lapthorn solicitors and Harriet Jerram. As the decision was made so late in the day, both the solicitors and Counsel were acting pro bono in all their preparations for the inquests. This situation led to Blake Lapthorn being *"embarrassed [in their] professional relationship with Counsel"* and feeling *"compromised in our ability to conduct the case properly for the relatives … to the point of destruction"* (PCO001032, p1).

8.101 The documents demonstrate the difficulties that Blake Lapthorn solicitors and Harriet Jerram experienced throughout the coronial process while the matter of funding remained unresolved. Both the solicitors and Counsel carried out a considerable amount of work before the inquests began, and even as the inquests were progressing they did not know if they would ever be paid. Their professionalism and dedication ensured that the families had some degree of representation.

8.102 Blake Lapthorn solicitors made an application for *"exceptional funding"* in respect of Mrs Richards' inquest on 22 April 2009, the day after the jury returned verdicts in respect of the ten inquests (LAA000049). A letter was also sent to the LSC enclosing a briefing document that outlined the police investigation into the death of Mrs Richards (LAA000044). The Coroner wrote to Blake Lapthorn solicitors reiterating his support for Mrs Mackenzie to be granted funding for representation at the inquest, as *"I feel that her being legally represented at the hearing will vitally assist both her and myself"* (BLC003445).

8.103 Following the decision of the CPS in 2010 not to bring any criminal prosecution in the case of Mrs Richards, Mr Horsley drew back from his earlier support for the provision of funding to Mrs Mackenzie. He informed Blake Lapthorn solicitors that *"I am not convinced that there are now any exceptional circumstances relating to the forthcoming inquest warranting your client receiving legal aid and would prefer to take a neutral stance in the matter of her obtaining such funding"* (PCO002126, p2).

8.104 On 3 September 2010, Blake Lapthorn solicitors wrote to the LSC again about their application (LAA000029). Following the first pre-inquest hearing, Blake Lapthorn had written to the Coroner with submissions prepared by Counsel as to why exceptional funding should be granted for Mrs Mackenzie's representation at the inquest (PCO002099). Mr Horsley decided to support the application (PCO002098). Shortly thereafter ministerial approval was granted to provide funding for the inquest (LAA000022), although this was not confirmed to Blake Lapthorn until 3 October 2010 and even then it was at a significantly lower level than had been claimed by Blake Lapthorn or approved by the Minister (BLC003715).

Whether the inquests should have proceeded on the basis that Article 2 of the Human Rights Act was engaged

8.105 It appears to have been widely assumed and accepted in the initial stages that the inquests would proceed on the basis that Article 2 of the Human Rights Act was engaged. At his meeting with the Ministry of Justice and DH in August 2007, Mr Horsley had said that *"Article 2 ECHR was clearly engaged … but the size and complexity of the evidence was likely to go beyond the comprehension of a jury"* (PCO000128, p3). The agenda for the pre-inquest hearing in August 2008 made no mention of Article 2 (PCO000283, p5). In addition, there appears to have been no discussion at the pre-inquest hearing as to whether or not Article 2 was engaged

(PCO000736), and Counsel for the families made written submissions on the basis that it was engaged (BLC000648).

8.106 The documents show that this position changed significantly when the solicitor for the Trust contacted Mr Bradley in October 2008 (MRE000930). This was the first of a number of telephone conversations that the solicitor for the Trust had with the Coroner in the absence of the legal representatives of any other properly interested parties. The solicitor for the Trust expressed surprise at Mr Bradley's view that the Human Rights Act was engaged. All the individuals had died before the Human Rights Act had become law.

8.107 The Coroner accepted that, on the basis of the authority that the solicitor for the Trust had referred him to, Article 2 was not engaged. Although the solicitor for the Trust appears to have suggested to the Coroner that this decision be communicated to the other interested parties, *"as they may take the view that [Article 2 of the Human Rights Act] should be engaged"* (PCO000714, p2), the Coroner appears not to have done this.

8.108 On 15 January 2009, the solicitor for the Trust wrote to the Coroner asking if written submissions needed to be made in respect of the Article 2 issue (PCO000602). None were submitted. The first time the question appears to have been brought to the attention of the other interested parties was at the pre-inquest hearing in January 2009, when the solicitor for the Trust asked if Article 2 was engaged and the Coroner said that on the authorities it clearly was not (MRE000981, p4; BLC001839, p3). No other representatives addressed the issue.

8.109 The decision on Article 2 was an important issue that should have been notified in advance to the other interested parties so that they could consider making representations.

8.110 As an inquest where Article 2 was not engaged, sometimes known as a 'Jamieson' inquest, the Coroner was required to look into how the deceased came by their deaths, but not the wider issue of in what circumstances.

8.111 In the subsequent inquest into the death of Mrs Richards, Mrs Mackenzie believed that Article 2 could have been engaged. At the first pre-inquest hearing, Mr Horsley stated that *"as regards systemic failure this is not an Article 2 inquest"* (PCO001778, p13). In an email to Mark Waldron of the *Portsmouth News* on 5 November 2012, Mrs Mackenzie said that she had been *"informed by Mr Horsley that he is not going to consider case under Article 2 of the Human Rights Act as although the Human Rights Act in the pipeline in 1998 it was not in situ until 2000"* (FAM103243).

8.112 In March 2013, only weeks before the inquest was due to begin, Mr Horsley wrote to Mr White to say:

> "… as I have previously made clear, Article 2 of the European Convention on Human Rights is not engaged in respect of Mrs Richards' death. For this reason, my verdict at the end of the inquest must be limited to expressing my conclusion upon how she died but not upon the circumstances in which she died." (PCO002055, p2)

When the issue was raised at the pre-inquest hearing in May 2011 (PCO001778) – following the cases of *McKerr* and *Hurst* – it was clear that Article 2 *"could not"* apply as Mrs Richards had died before the Human Rights Act came into force. However, the Panel notes that one week later, the Supreme Court delivered the judgment in the case of *McCaughey* ([2011] UKSC 20). This stated that, in respect of a death that occurred before the Human Rights Act came into force, if the inquest takes place after the operative date (as Mrs Richards' inquest clearly did) then Article 2 could be engaged.

Rule 43 of the Coroners Rules 1984: action to prevent the recurrence of similar deaths

8.113 Mills & Reeve LLP was instructed to represent Portsmouth Hospitals NHS Trust. Weightmans LLP was instructed to represent Hampshire Primary Care Trust. The organisations jointly instructed Counsel, Briony Ballard, to represent their collective interests at the inquests. It is clear that the solicitors representing the Trust were keen to ensure, as far as was possible, that the Coroner did not issue a Rule 43 letter. Rule 43 of the Coroners Rules 1984 provided that:

> "… a Coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of the inquest is being held, may announce at the inquest that he is reporting the matter in writing to the person or authority who may have the power to take such action and he may report the matter accordingly." (GMC000675, p105)

The practical effect of Rule 43 was that a Coroner could extend the scope of his/her enquiry and questioning beyond that which was strictly necessary to answer the question of 'how' the deceased came by their death, even though the jury would not return a verdict on such matters (these principles are now reflected in Rule 28 of the Coroners Investigations Regulations 2013).

8.114 In their instructions to Counsel in January 2009, Mills & Reeve LLP, in considering what material the Trust should supply to the Coroner, stated:

> "… we should limit the evidence to suggest to the Coroner that he considers three main issues: to assist him in determining 'how' these patients met their deaths; to put the work on DMOP [the Division for Medicine for Older People] and GWMH [the hospital] into context to aid understanding; and to avoid a Rule 43 letter requesting changes/review of the service and which would be published to the government (and almost certainly be made public straight away)." (MRE000211, p14)

8.115 The Trust sought to deal with the possibility that Mr Bradley might issue a Rule 43 letter and set about preparing evidence. In October 2008, Lesley Humphrey, the Trust's Director of Quality, started to prepare a chronological account of events and management responsibility. This document, which appears to have received input from a number of stakeholders, eventually became a draft witness statement to deal with any potential Rule 43 issues (MRE000707, MRE001098).

8.116 In advance of the second pre-inquest hearing, the solicitor for the Trust rang Mr Bradley and told him that he was intending to forward a statement and documentation from the manager of the service. His aim was *"to put the management of the service into context so that he understood what was happening and also demonstrate the level and provision of service today in order to avoid a potential Rule 43 letter"* (MRE001052).

8.117 Mr Bradley indicated that he *"would rather not receive any additional information from the NHS because he does not want to examine post event issues and changes. He does not want to promote others to make such an investigation."* Mr Bradley also indicated that *"he had already excluded investigation material from the police and other sources which he was under pressure from the family to accept. He had told family members of his decision and that if they didn't like it they could JR him."* The Coroner also said that any documents that were disclosed to him would need to be disclosed to the other parties, *"and he wants to avoid that if at all possible"* (MRE001052).

8.118 The solicitor for the Trust passed on the message to the Trust that there would *"almost certainly be no Rule 43 letters because the events were 10 years ago"* (MRE001037). Both he and Mr Mellor were slightly surprised by the *"robust"* view that the Coroner was taking, but considered this to be *"a good result for the NHS"*.

8.119 Despite hoping that the Coroner would not issue a Rule 43 letter, the Trust was keen to ensure that, pursuant to Rule 43, some evidence was heard during the course of the inquests about the present state of the hospital and how things had improved. In July 2008, an inquest 'steering group' was set up with the aim of managing the *"Coroner's inquests effectively in order to maintain the continuity, quality and confidence of local people in health services in Gosport"* (MRE000260, p1). The steering group met on a number of occasions and received input from the solicitor for the Trust. The topics discussed at meetings included the approach of the Coroner to the inquests (MRE000647, p2), the communication strategy (MRE000244, pp1–2) and the best approach to addressing, through evidence, any potential Rule 43 issues (MRE000244).

8.120 At the second pre-inquest hearing, the solicitor for the Trust raised the issue of Rule 43 and asked whether the Coroner would allow *"evidence under Rule 43 which may go some way to helping the families with their issue and would certainly offer reassurance to the wider public"*. The Coroner replied that *"he will not hear evidence under Rule 43 as this was 10 years ago and that he cannot address history"* (MRE000981, p4). Furthermore, Mr Bradley questioned what purpose a Rule 43 letter would have at that point in time: under Rule 43, concerns can be reported to a public body, but in the present case there was *"no point"* as the public body in question was no longer in existence (BLC001839, p3).

8.121 Following the second pre-inquest hearing, the solicitor for the Trust spoke to Mr Mellor. He expressed his concern that, although the inquest would not engage Article 2, the Coroner would allow wider questions from the families. However, there was nobody to answer those questions. The solicitor for the Trust felt that he had offered the Coroner a *"way out"* by suggesting that he call or present evidence, but the Coroner had declined to take that route. The solicitor for the Trust expressed the opinion that, although the matters in question were ten years old, the Coroner should still address them in case there was evidence to suggest similar fatalities might occur in the future (MRE000980, p1).

8.122 Counsel instructed by the Trust appeared to agree that the Coroner *"really should take note of Rule 43"* (MRE000967, p1). At a conference with Counsel, it was stated that the Coroner had *"a statutory requirement to look into issues under Rule 43 though it appears he is not going to do so"* (MRE001459, p2). The Trust appeared to want to have certain evidence adduced during the course of the inquests in respect of the changes that had taken place, which it felt had led to improvements. As set out above, Lesley Humphrey was identified as an appropriate witness to *"put the matter into context"* and *"provide evidence"* of the *"factual changes and explain the current situation within the service"* (p3).

8.123 In the event, consideration was given as to what other evidence the Trust wanted to place before the Coroner in relation to the state of the service as it then was (MRE001353).

The decision to hold the inquests with a jury

8.124 Persuading the Coroner to hear the inquests with a jury appears to have been one of the priorities of the families who instructed Blake Lapthorn solicitors to represent them during the course of proceedings. Counsel instructed to represent the families at the pre-inquest hearing was specifically instructed to make submissions seeking a jury inquest (BLC000657, pp4–5). In her written submissions, Harriet Jerram suggested that the inquests should be heard by a jury pursuant to section 8(3)(d) of the Coroners Act 1988, namely that *"the death[s]*

occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health and safety of the public or any section of the public" (BLC000652, p4). At the first pre-inquest hearing on 14 August 2008, Mr Bradley determined that the inquests into the ten Category 3 deaths would proceed as one inquest and that the case would be determined by a jury (PCO000736, p1). Mr White for the families considered this to be *"an excellent outcome"* (PCO000736, p2).

8.125 By contrast, the Coroner ruled that he was not going to call a jury to consider the inquest into the death of Mrs Richards because *"I don't feel that it fulfils the criteria under section 8 of the Coroners Act"* (PCO001778, p8). Mr Mehigan argued that *"this may well fall into 8(3)(d)"*; that is, *"the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public"*. Mr Horsley took the view that the previous ten inquests had determined the issue under section 8(3)(d) and that *"it would [not] be in the public interest to have a jury in this case. I think it would be quite legitimate for me to determine this inquest on my own"* (p9).

The treatment of expert evidence

8.126 The file of documents provided to Mr Horsley on 11 April 2007 made him aware of a number of expert reports. These included Professor Brian Livesley's reports into the death of Mrs Richards, reports from Professor Ford and Dr Keith Mundy, a consultant physician and geriatrician, and Professor Baker's statistical report. The file also included Dr Wilcock's draft report on common features of the ten cases, including extracts from the reports of Professor Black.

8.127 Mr Horsley was aware that there had been other expert evidence. He told the Ministry of Justice that there were *"39 experts' reports"*. He expressed his concern *"about the large number of expert witnesses"* and *"that the size and complexity of the evidence was likely to go beyond the comprehension of a jury"* (PCO000058, p3; PCO000128, p3).

8.128 In anticipation of the first pre-inquest hearing, Harriet Jerram's written submissions stated that among the evidence that was *"likely to be of assistance"* was *"generic expert evidence regarding the prescribing and administration of opiates. Disclosure is invited of the expert evidence obtained by Hampshire Constabulary as part of its investigations. Alternatively, the Coroner is invited to obtain such evidence."* There was also *"in individual cases, expert evidence on the use of opiates in the deceased's case and whether that caused or materially contributed to the deceased's death"* and *"where appropriate in any case, expert evidence on any other matter relating to the care of the deceased at the hospital which may have caused or materially contributed to the deceased's death"* (BLC000648, pp5–6).

8.129 At the first pre-inquest hearing it was determined that Dr Wilcock and Professor Black, the two experts instructed by the police, would give live expert evidence (PCO000736, p1).

8.130 The Coroner's decision to include in the advance disclosure, and subsequently to rely upon, the evidence of Dr Wilcock and Professor Black was met with criticism from both the families and the Trust, for different reasons. At the second pre-inquest hearing, Mr Bradley said that he had chosen the two experts *"that he liked"* (BLC001839, p3). He does not appear to have given consideration at any stage to instructing a new independent expert to look at the deaths purely from a coronial perspective.

8.131 In a report prepared for the Trust in December 2008, the solicitor for the Trust noted that *"the experts were originally instructed by the police to consider any criminal actions and that is*

not the purpose of the inquest. They should be asked to be clearer in their view as to how these patients met their death" (MRE000283, p3).

8.132 Clearly perturbed by the criticism contained in Dr Wilcock's report, Dr Reid wrote to the solicitor for the Trust questioning Dr Wilcock's expertise:

> "… how much experience has [he] in managing elderly patients who have sustained a fractured hip with complications and elderly patients with gross obesity, immobility and extensive pressure sores … his lack of experience in elderly medicine, would lead me to question his suitability as an expert witness at an inquest, the primary purpose of which is to determine cause of death." (MRE000988, p4)

8.133 Thereafter, the solicitor for the Trust attempted to steer Mr Bradley away from relying on Dr Wilcock and instead to rely solely on Professor Black. At the second pre-inquest hearing, the solicitor for the Trust raised the issue of Dr Wilcock's suitability. He referred to the report on Mrs Spurgin, claiming that it was inaccurate and displayed a lack of understanding of end of life care. He asked whether, on the basis of his CV, Dr Wilcock was an appropriate expert and said that he might be embarrassed by questioning during the inquest. The Coroner, however, thought that Dr Wilcock was appropriate and had experience in rehabilitation of the elderly (MRE000981, p3).

8.134 The solicitor for the Trust followed up this issue after the pre-inquest hearing by writing to the Coroner again, stating:

> "… it would not be our intention to embarrass or discredit Dr Wilcock but would respectfully request that you confirm with him, in advance, that he feels he is able and an appropriate person to deal with questions concerning the management of those on 'end of life care'. His CV suggests experience in acute medicine and rehabilitation and I am concerned that that is not the same thing." (MRE000964, p2)

8.135 Mr Bradley wrote to Dr Wilcock setting out that, at the pre-inquest hearing, questions had been asked about Dr Wilcock's areas of expertise and whether they extended to geriatric end of life care. Mr Bradley stated that the issue for the inquests would be the appropriateness and suitability of the care of the ten deceased who were the subject of the proceedings: *"could I trouble you to provide your thoughts as to whether you are 'the right man for the job' to give this particular type of evidence"* (PCO000614, p1).

8.136 Dr Wilcock responded that he believed he had been approached *"because of the extensive experience of the use of opioids and other symptom relieving drugs in palliative care, particularly in those patients who are dying"*. He said that if the Coroner wanted a *"real world/ coal face"* view rather than the ideal treatment, it might be that the geriatrician called as a witness could provide better evidence (PCO000983). It is perhaps as a result of this email that Mr Bradley saw fit to refer to Dr Wilcock, during the course of the inquests, as *"the drugs man"*.

8.137 Mr Bradley wrote to the solicitor for the Trust indicating that he would be relying on both Dr Wilcock and Professor Black as he felt they were *"complementary"* (PCO000597).

8.138 While members of the Trust may not have been entirely satisfied with the expert reports of Dr Wilcock, family members expressed their own concerns about Professor Black. Ann Reeves, Elsie Devine's daughter, wrote to Mr Bradley asking for a review of his opinion to identify *"inaccuracies and bias"*. She suggested that, as a former employee of Portsmouth HealthCare NHS Trust, Professor Black could not remain independent (PCO000873).

8.139 The Coroner refused to allow the reports of Dr Wilcock and Professor Black to be put before the jury in their entirety, as they had been prepared for a different purpose from an inquest, and potentially contained material that was unsuitable to go before an inquest jury. Instead, the jury would be allowed to listen to the live evidence of each of the experts (PCO000597).

8.140 While there were concerns relating to the experts the Coroner had chosen to give evidence at the inquests, some family members were even more concerned that not all the expert reports had been included in the advance disclosure. On 20 November 2008, Mr Stewart-Farthing wrote to Mr Horsley, copying in Mr Bradley (PCO000664). Mr Stewart-Farthing questioned why only the reports of Dr Wilcock and Professor Black had been included in his stepfather's file and requested that the reports of Dr Mundy and Professor Ford be released, *"as they formed the basis for the aborted prosecution in 2002 and therefore are likely to contain significant information relating to this case"*. Mr Stewart-Farthing also expressed his concern that:

> "… the Chief Medical Officer continues to withhold Professor Baker's 2002 audit of this hospital, and also a report by Professor Forrest which categorises the various cases by degree of seriousness with a view to proceeding with prosecution, as these too will have a direct bearing on the regime that existed at the time." (PCO000664, p1)

8.141 On 21 November, Mrs Reeves wrote to Mr Bradley, copying in Mr Horsley, to set out the documents that she considered were missing. These included *"Professor Forrest's expert medical opinion and his team, bearing in mind he was the first expert the police took advice from"*; *"Professor Richard Baker's audit re GWH"*; and *"Mr Matthew Lohn expert opinion"* (PCO000666, p1).

8.142 Mr Bradley responded to both Mr Stewart-Farthing and Mrs Reeves on 21 November. He was not conducting a public inquiry and the ambit of the proceedings was limited. Mr Bradley said that it was for him to decide the evidence and to consider how much of it would enable the jury to answer questions raised by the inquisition. He also stated that the purpose of the inquest was not to apportion blame (PCO000667).

8.143 In response, Mr Stewart-Farthing stated that *"the information provided thus far is incomplete, inadequate and could very well be misleading if the full picture is not visible"* (PCO000003, p3).

8.144 Mrs Reeves wrote to Mr Bradley on 13 January 2009 expressing her concern that Professor Forrest's *"expert opinion"* had not been released. The opinions that she had reviewed were *"incomplete, contradictory and misinformed"* (PCO000628, p1).

8.145 At the second pre-inquest hearing, Mr Iain Wilson raised the issue of the reports of Professor Ford and Dr Mundy that had not been disclosed, which were relevant to his father's death. The Coroner ordered that these reports be disclosed. Professor Ford's report was significant because he was a professor of pharmacology and had provided expert opinion in relation to the treatment of two of the subjects of the inquests: Mr Cunningham and Mr Wilson. In respect of Mr Cunningham, Professor Ford said:

> "… the initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory

> depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression." (BLC002635, pp10–11)

8.146 In respect of Mr Wilson, Professor Ford said that he was *"inappropriately treated with high doses of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death"* (FAM100459, p16). Professor Ford also raised more general concerns, based on his review of the five cases, about the clinical management of elderly patients at the hospital.

8.147 Dr Mundy had provided the police with an opinion in relation to the treatment of Mr Cunningham in which he said that *"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"* (DOH603309, p4).

8.148 Neither Professor Ford nor Dr Mundy were called to give evidence in person.

8.149 In addition, there appears to have been no mention of either Professor Forrest's report or Professor Baker's statistical report at the second pre-inquest hearing (PCO000501). Mrs Reeves emailed Mr Bradley on 3 February 2009 to ask if he would release *"Professor Forrest's expert opinion … He is the 'top man' who the police called upon from the beginning … I find it extraordinary that his opinion is not being included"* (PCO000592, p3). Mr Bradley responded: *"The reason I am not calling Prof Forrest is precisely because he was instructed to look at the matter from the point of view of prosecution and I cannot do that"* (p2).

8.150 Mrs Reeves responded to the Coroner as follows:

> "This is the first time that I have heard that Prof Forrest was instructed to look at the matter from the point of view of prosecution. Please can you elaborate further. All experts must remain non bias and purely factual in their area of specialisation … We are looking towards unlawfully killing, are you excluding Prof Forrest Report if you say his opinion was from the point of prosecution because you are looking at a verdict of system neglect?" (PCO000592, p2)

8.151 Mr Bradley responded:

> "Professor Forrest was instructed by the police to look at this situation from the point of view of criminal proceedings and that is why I do not want to take a partisan opinion to put before a jury. What you want is irrelevant to me in my enquiry … My job is to complete an inquisition and not to enter any kind of judgment. The jury will give a conclusion after they have heard all the evidence that I believe is impartial and will enable them to do the job they are empanelled to do." (PCO000592, p2)

8.152 On 23 February 2009, Blake Lapthorn solicitors wrote to Mr Bradley requesting disclosure of a number of items, including Professor Forrest's opinions, the 1991/92 nurses' dossier of concerns and Professor Baker's report from 2002 (PCO000576, p2). Mr Bradley passed their letter to Detective Sergeant (Det Sgt) Roy Stephenson and said: *"I cannot find any report from Professor Forrest in any of the paperwork that I have nor do I have the 1991 document or Professor Richard Baker's report"* (HCO001220). In an email response on 3 March, the officer said that *"this matter [Professor Forrest's report] has already been dealt with by email to you dated 27/02/09"* (PCO000563, p1). There is no email dated 27 February 2009 dealing with these documents in the papers provided to the Panel.

8.153 Mr Stewart-Farthing and Mrs Reeves both continued to ask Mr Bradley for Professor Forrest's report (PCO000871, PCO000160). On 9 March, Mr Bradley told Mrs Reeves that *"I do not have Professor Forrest's opinion and I do not believe it was ever reduced to writing"* (PCO000873, p2).

8.154 On the first day of the inquests, Mr Leeper, Counsel instructed by a number of the families, raised the issue of Professor Forrest's report. Mr Bradley said:

> "There is not a report from Professor Forrest. As I understand it, this again does not form part of it because Professor Forrest was instructed for another purpose. I think I am right in saying that there is not a report from Dr Forrest. I think the police consulted Dr Forrest but there is not a report from him. I have not got one; I have never seen one." (CPS000004, p6)

8.155 Following this, Mr Leeper asked the Coroner to consider calling Professor Forrest as a witness in the course of proceedings, on the grounds that *"he is clearly an eminent toxicologist and we are not going to be hearing from anybody with the same area of expertise"* (CPS000004, p8). Mr Bradley expressed his concern about taking toxicological evidence when only one of the ten deceased had had a post mortem. He also questioned *"what has toxicology got to tell us … after 20 years"* (CPS000004, p9). The Coroner concluded that he would not hear from Professor Forrest without a report.

8.156 One of the family members who attended the first day of the inquest forwarded the transcript of the hearing to Professor Forrest. On 19 March, Professor Forrest emailed Mr Bradley and said:

> "… the report that my team produced … was never intended to be evidential but was rather a screening exercise designed to identify those cases that gave rise to particular concern … those cases to then be reviewed by other experts who would produce reports on individual cases in detail that the CPS would eventually consider and which, absent prosecution, would be eventually passed on to you." (PCO000973, p1)

8.157 In resisting requests to widen the expert evidence, for example to include that of Professor Forrest, the records show the Coroner to have used reasons based on his own view as to why some reports were inadmissible and should not be relied upon. As a result of the approach taken, the records show that no expert evidence from a toxicologist or pharmacologist was sought, despite the central issue of the prescribing of diamorphine.

8.158 By contrast with the formal relationship Mr Bradley had with the legal representatives of the families, for example over expert evidence, the Panel has seen a different and closer relationship with the solicitor for the Trust. For example, on 27 January 2009 the solicitor for the Trust wrote to Mr Bradley and asked if he was intending to write to the experts:

> "… to brief them before they give evidence on the relevant questions and considerations you will require them to comment on to the jury? I wonder if that might be helpful so the experts are clear as to what is expected of them in terms of how and by what means these patients met their deaths? If you could copy me in on any correspondence that would be extremely helpful." (PCO000595, p1)

8.159 The documents show how the issue of expert evidence arose again in the inquest into the death of Mrs Richards. On 18 August 2010, Blake Lapthorn solicitors wrote to the Coroner asking *"to be able to make representations in relation to medical expert evidence"* (PCO002127, p1). Mr Horsley responded that he was *"considering myself calling expert medical*

evidence" (PCO002126, p1) and later indicated that he would be *"instructing an independent medical expert to give me an opinion on the appropriateness of the hospital treatment Mrs Richards received and whether it might have made a significant contribution to her death"* (PCO002119, p1). Blake Lapthorn solicitors requested disclosure of the reports prepared by Professor Ford, Professor Livesley and Dr Mundy (BLC003233, p1).

8.160 In the event, Mr Horsley chose Professor Black as his *"independent medical expert"*. This was despite the fact that Professor Black had given evidence at the previous inquests, had been instructed by the police to prepare reports in relation to deaths at the hospital, and had originally prepared a report on Mrs Richards.

8.161 Meanwhile, Blake Lapthorn solicitors continued to press the Coroner to disclose the reports of Professors Livesley, Ford and Baker (PCO002103). The matter was raised again at the first pre-inquest hearing, when Counsel for Mrs Mackenzie said that Professors Livesley and Baker had both produced reports on Mrs Richards' death that the family had not been able to see. Mr Horsley quickly shut down this issue:

> "You are not going to see them via me because I commissioned my own independent expert, Dr Black, to look at things fresh from the point of view of what I had to do at the inquest so I am not interested in those reports." (PCO001778, p15)

8.162 Blake Lapthorn solicitors continued, unsuccessfully, to seek disclosure of the reports from Professors Ford and Livesley (PCO002086, pp1–2) and eventually obtained them from the GMC (BLC004727). However, the Coroner continued to refuse to allow those experts to give evidence and suggested that Mrs Mackenzie obtain her own expert if she did not accept the conclusions set out in Professor Black's report (BLC004727). Blake Lapthorn solicitors, therefore, sought to instruct Professor Forrest to prepare a report (BLC004735).

8.163 Blake Lapthorn solicitors encountered some difficulties in obtaining a report from Professor Forrest, so instructed Professor Ferner instead (BLC004551). Professor Ferner's report noted that, as part of the KCT, he had considered the case of Mrs Richards, as one of 91, to determine whether, for the purposes of a criminal prosecution, he could be satisfied beyond reasonable doubt that negligence caused death, and that this negligence could be categorised as 'gross'. He had not considered it possible to demonstrate to the required standard that Mrs Richards' death was anything other than natural, or that there had been negligence. He believed that the prescribing had been sub-optimal (BLC004232).

8.164 However, in his report for Mrs Richards' inquest, Professor Ferner stated that *"it is therefore very likely that the administration of subcutaneous diamorphine, and the concurrent administration of midazolam and haloperidol, rendered Mrs Richards too drowsy to take oral fluids, increased the risk of her developing renal failure, and hastened her demise"* (BLC004232, p16). Professor Ferner also prepared a supplementary report, responding to the points raised by Professor Black (PCO001889). Professor Ferner agreed with much of what Professor Black said but disagreed with the assertion that *"40 milligrams of diamorphine by subcutaneous infusion was a suitable dose in a woman whose pain was evidently controlled by oral morphine"* (PCO001889, p2). Significantly, Professor Ferner said: *"I am clear that, on the balance of probabilities, the administration hastened death"* (p3).

Conclusion: what is added to public understanding

- The documents show little justification for the delay between the Crown Prosecution Service decision in December 2006 and the eventual start of the pre-inquest hearings listed for 14 August 2008.
- The documents show little justification for the decision to hold the inquest into the death of Gladys Richards separately.
- The Panel notes that the test for whether a case should be the subject of criminal prosecution is significantly different from the test for whether it should be the subject of an inquest by a Coroner. A Coroner is required to hold an inquest in cases where he/she has reasonable grounds to suspect that the deceased has died a violent or unnatural death or has died a sudden death of which the cause is unknown. A death that the police consider does not involve evidence of 'unlawful criminal activity' or 'negligence' by the treating clinician could still necessitate an inquest by the Coroner.
- On the basis of the papers that the Panel has seen, it appears that the Coroner and Assistant Deputy Coroner were given very little information by the police in relation to the other 81 deaths, but no effort appears to have been made to make any further enquiries in relation to those deaths. The findings of the Key Clinical Team in relation to each of the 81 deaths clearly showed that, in their expert opinion, the cause of death was unclear in far more than the ten Category 3B cases. The Coroner should, therefore, have considered these cases for inquests. The findings of the Key Clinical Team in this regard were held by the police and were readily accessible; they were forwarded to the General Medical Council for the purposes of the General Medical Council's investigation into Dr Jane Barton's fitness to practise and, even if they were not provided to the Coroner, would have been readily available to him.
- Day one of the inquest hearings was 18 March 2009. The Panel notes that this was over two years after the Coroner took a provisional view in relation to the requirement for him to hold inquests into the ten deaths.
- The documents show the Coroner's opinion on those verdicts that would have reflected the families' concerns: *"trite Home office category verdicts are not going to answer people's questions. You can walk away with an open verdict, you can walk away with unlawful killing, but it actually does not answer the questions that people want to have answered."*
- The documents show that the Coroner declined to adopt a wider approach to the inquests and the opportunity offered by Rule 43 of the Coroners Rules 1984 to prevent similar deaths in the future.
- Mr Bradley had no reports before him from experts entirely independent of the criminal investigation and chose to rely upon two experts whom he knew the police had instructed. Neither Professor Gary Ford nor Dr Keith Mundy, for example, were called to give evidence in person. In resisting requests to widen the expert evidence, for example to include that of Professor Robert Forrest, the Coroner appears from the records to have used reasons based on his own view as to why some reports were inadmissible and should not be relied upon. As a result of the approach taken, the records show that no independent expert evidence from a toxicologist or pharmacologist was sought, despite the central issue of the prescribing of diamorphine.

Chapter 9: The local and national media

Introduction

9.1 The Panel has seen no documents suggesting that the concerns expressed by the nurses at Gosport War Memorial Hospital ('the hospital') in 1991 were drawn to the attention of either the local or national media at the time.

9.2 The documents available to the Panel show that the first time the local or national media covered the relevant allegations was in April 2001, over two and a half years after Gillian Mackenzie contacted Hampshire Constabulary, thereby bringing about the police investigation.

9.3 In April 2001, it was the local newspaper in Portsmouth, *The News*, which began to publicise the ongoing police investigation. For ease of reference, the newspaper is referred to in this Report as the *Portsmouth News*.

9.4 The press reports described in this chapter are available on the Panel website.

Initial media coverage: 2001

9.5 The documents show that, on 22 March 2001, Detective Superintendent (Det Supt) Steve Watts included the following statement in a note headed *"Various media issues re OP ROCHESTER & THORNHILL"*: *"As you are aware this afternoon I was contacted by Jonathan CARTER of the News asking for a meeting to discuss some information that he had regarding our investigation of a death at Gosport Memorial Hospital"* (HCO003619, p1).

9.6 It appears that Det Supt Watts met Mr Carter on the same day. Det Supt Watts sent his note to Detective Chief Inspector (Det Ch Insp) Raymond Burt, then the officer in charge of the police investigation, and to a Hampshire Constabulary media services officer. He also copied the note to Detective Inspector (Det Insp) John Ashworth, Detective Chief Superintendent (Det Ch Supt) Keith Akerman, Chief Superintendent (Ch Supt) David Basson, Head of the Professional Standards Department, and a detective sergeant. The note said:

> "ROCHESTER – You very helpfully e-mailed to me the 'if asked' press strategy which was very useful in my meeting with Jonathan. He immediately indicated to me that he had received a telephone call from Mrs Gillian MACKENZIE, she told him that the PCA had just released its findings in respect of a discipline enquiry regarding two Detectives from Gosport including a DI. Jonathan said that he had called C/Supt BASSON & had confirmed this.
>
> Mrs MACKENZIE went on to tell him that we had launched a further investigation into the death of her mother at Gosport WM Hosp. Jonathan went on to say that other

> enquiries he had made with a 'source' indicated to him that this may be another 'Shipman' and that it was a story worth following – he mentioned the surprisingly accurate figure of 600 possible related deaths.
>
> Without confirming anything else, I gave him almost verbatim the 'if asked' line and he will quote that I am sure. Jonathan intends to run the story soon and will I suspect go on the line of a possible mass killer.
>
> Ray; I know that you have spoken to the Health Trust – could you also warn the relevant CPS re this. It may act as a catalyst for an earlier response. Also it may be helpful to speak with Mrs MACKENZIE to effect some damage limitation." (HCO003619, p1)

9.7 Det Supt Watts ended the relevant section of his note in these terms: *"The above for info of all concerned - obviously Jonathan now has a new good source. Ray & I will speak tomorrow"* (HCO003619, p1).

9.8 It is clear from the documents that Hampshire Constabulary immediately alerted Portsmouth HealthCare NHS Trust to the approach from the *Portsmouth News*. On 23 March, Lesley Humphrey, Quality Manager for the Trust, informed Max Millett, Chief Executive of the Trust, along with others including Eileen Thomas, Nursing Director, Ian Piper, Operational Director, Peter King, Personnel Director and Dr Richard Ian Reid, Medical Director and also a consultant at Gosport War Memorial Hospital (DOH600033).

9.9 On 3 April, the *Portsmouth News* published the story on its front page under the headline *"Probe Into Suspicious Death at Hospital – police investigation into alleged unlawful killing of patient, 91".* The article suggested that detectives had prepared a dossier on the death and that the police might have to re-examine up to 600 other deaths at the hospital (OSM100767, p1; OSM100766, p1).

9.10 The front page newspaper article stated that the hospital was now *"at the centre of a major police investigation into the alleged unlawful killing of an elderly patient"*. It pointed out that nobody had been arrested or questioned under caution but said that a file had been sent to the Crown Prosecution Service (CPS) following a complaint to police by Mrs Mackenzie about the standard of care given to her mother (OSM100766, p1).

9.11 The article was combined with a full-page investigation on page 3 – *"Mystery at the War Memorial"*. The newspaper reported that Gosport had fought to save its hospital:

> "The people of Gosport are intensely proud of the complex – and very defensive of it. When it was threatened with closure in a 1980s health shake up, a huge campaign was launched. The campaign didn't merely convince health chiefs to keep it open but also to invest in it, and a £10m revamp was ordered which made the hospital much bigger and gave it a range of state-of-the-art facilities." (OSM100766, p1; DOH603574, p1)

9.12 The page 3 investigation also stated: *"Today [Gladys Richards'] daughter, Gillian Mackenzie, refused to be drawn on the inquiry but said 'I hope that I will never see anyone die in the circumstances in which my mother died.'"* The report went much further than citing just one case: *"One source told the News the deaths of as many as 600 elderly people could be re-examined. It is thought the use of the pain killing drug diamorphine might form part of any future inquiry"* (OSM100766, p1; DOH603574, p1).

9.13 Hampshire Constabulary confirmed the investigation into the death of one patient in both a statement and a comment from two senior officers, who stressed that Portsmouth HealthCare NHS Trust and the Royal Hospital Haslar had cooperated fully in their investigation. Det Supt Watts would not comment on the inquiry. However, he did say: *"I can confirm it is an allegation of unlawful killing"* (OSM100766, p1; DOH603574, p1).

9.14 The *Portsmouth News* pressed Det Ch Insp Burt about the investigation into other deaths. He was quoted as saying:

> "When the CPS makes a decision in this case, whatever that might be, a decision will be made as to what would be the most appropriate course of action to take. We are conscious of the fact that we are dealing with extremely sensitive issues and any decision about further action will be taken with great care and consideration for all persons who may potentially be involved." (OSM100766, p1; DOH603574, p1)

9.15 The article suggested that the Trust was aware of the investigation, had cooperated and took both complaints and patient safety very seriously. Mr Piper was reported as saying: *"The trust did receive a complaint in August 1998 over the standard of care related to the lady concerned. We always take complaints very seriously and that complaint was investigated"* (OSM100766, p1; DOH603574, p1).

9.16 In an accompanying article on the same page, the *Portsmouth News* reported Mrs Mackenzie's criticisms of the police investigation under the headline *"Daughter's complaint leads to rap for detectives"*. Mrs Mackenzie is quoted as saying:

> "I went with a serious concern to Gosport Police station and they prepared a file for consideration by the CPS. The file contained no statements – not even a written statement from me – no interviews and no medical reports. In fact I don't know what they had in the file. Literally within a few weeks, I had a phone call from the police officer saying it was his opinion there was no case to answer." (OSM100766, p1; DOH603574, p1)

9.17 The newspaper reported that the Police Complaints Authority had disciplined Detective Inspector (Det Insp) Stephanie Morgan for making an *"inappropriate remark"* to Mrs Mackenzie and a second officer for *"investigative failures"* (OSM100766, p1; DOH603574, p1).

9.18 The coverage of the story by the *Portsmouth News* prompted other action. Nine days later, Pauline Spilka, a nursing auxiliary, explained that reading the articles had led her to come forward:

> "This story has brought back some disturbing memories of incidents that occurred whilst employed at the hospital that I felt unable to highlight at the time. Having read this story I have decided that I am morally obliged to bring them up now." (HCO110756, p1)

9.19 Hampshire Constabulary wrote to the editor of the *Portsmouth News*, Mike Gilson, objecting to a sentence in one of the 3 April articles, which stated that a complaint against the police by Mrs Mackenzie had been *"upheld"*. Ch Supt Basson, Head of the Department of Professional Standards at Hampshire Constabulary, wrote:

> "I was very disappointed to read an article on page 3 of your 3rd April edition concerning a complaint against police made by Mrs Gillian Mackenzie, where you inaccurately reported that the complaint had been 'upheld'.

As you will be aware, my department investigates such complaints and submits a report to the Police Complaints Authority for their decision. In this instance my investigating officer had concluded; 'this investigation has not found any of Mrs Mackenzie's allegations to be founded and no impropriety has been found on the part of either officer'.

This recommendation was accepted by the Police Complaints Authority. It is therefore, in my opinion, incorrect to say the complaint has been upheld and the officers 'disciplined'. Whilst it is correct that two officers received advice in relation to related matters, this is not a 'finding of guilt' nor a formal disciplinary outcome within the meaning of the Police Act 1996.

I would invite you to consider the appropriateness of correcting this matter, but would certainly ask you to correct your cuttings file so that any future reference to this matter is properly represented." (HCO007048, p2)

9.20 Mr Gilson replied on 19 April in these terms:

"I am sorry it has taken a little while to respond to your letter April 4. I have now had a chance to investigate the story of which you complain.

You will be aware that the Police Complaints Authority's view is that some of Mrs Mackenzie's complaints were indeed upheld. In a letter sent to Mrs Mackenzie by the PCA it describes the 'operational advice' given to your officers as 'not unlike a verbal warning' which we have taken to be some form of disciplinary action.

I have informed my news desk that this is not viewed as disciplinary action under the Police Act 1996 and thank you for clarifying the matter." (HCO501788, p1)

9.21 The day after publishing its initial story, the *Portsmouth News* reported that *"Suspicious death is under microscope"*:

"Health ministers are keeping a close eye on the unfolding drama at the Gosport war memorial hospital, it emerged today.

The Department of Health is refusing to comment officially on an investigation into the alleged killing of an elderly patient at the hospital until the Crown Prosecution Service has completed its findings.

But sources disclosed the case is being tracked at the highest levels – and has already been brought to the attention of health secretary Alan Milburn's office.

… A DOH source said: 'The department is keeping a very tight watching brief to see the outcome of the CPS investigation. If action needs to be taken as a result they will not hesitate to do that.'

… A Hampshire police spokeswoman said; 'As part of our research, officers have been collecting statistics at the hospital over a time period but that is a matter of routine.

We have received no other complaints and we have not reviewed or asked for any other hospital files. We are only looking at this one incident.'

> A spokesman for Mr Milburn said: 'This case is being investigated by the CPS so there is nothing further we can say about it at this time.'" (DOH603590, p1)

9.22 The *Portsmouth News* quoted Peter Viggers, MP for Gosport, as saying that Mrs Mackenzie's complaint was *"being properly handled by the police and by the Portsmouth Healthcare (NHS) Trust. I would only become involved if there was a breakdown of the normal authorities"* (DOH603590, p1).

9.23 In further coverage on 7 April, the *Portsmouth News* disclosed that three more families had come forward to the police with complaints about the treatment of their loved ones. The newspaper named two of them. Its article included an interview with Mike Wilson, the son of Edna Purnell:

> "Today, Mike Wilson, one of those at the centre of the fresh inquiries, said he had protested to a health watchdog that his mother, also 91, fell into a 'trance-like' state before she died at the War Memorial in December 1998.
>
> Edna Purnell, who lived in Lee-on-the-Solent, had been sent there to recuperate after a hip operation at Gosport's Royal Hospital Haslar.
>
> The health service ombudsman, who later examined a complaint by her son Mike Wilson against Portsmouth HealthCare (NHS) Trust, cleared the hospital of any blame for her death.
>
> The ombudsman concluded: 'I have not found evidence of unsatisfactory medical or nursing care, and I am satisfied that Mrs Purnell was not given excessive doses of morphine.'
>
> But the report criticised the hospital for the way in which some of Mrs Purnell's medical notes were destroyed. It said: 'The early destruction of the records was contrary to the trust's own policy and went against official guidance.'
>
> The [Portsmouth HealthCare NHS] trust expressed their deep regret for what had happened and said that it was the only time such an error had been made." (DOH603589, p1)

9.24 The second named case involved Jack Williamson, who died two days after his wife, Ivy. The newspaper reported his son as saying:

> "My mother had terminal cancer and was going to die. But with my dad I can't understand. When he died they said that he had given up, but to be dead within a week of my mum dying just seemed to be rather strange." (DOH603589, p1)

9.25 The reports in the *Portsmouth News* led to some, limited, coverage in national newspapers. *The Sun* carried a report on 9 April (OSM100960), and the following day a short article appeared in *The Times*, written by its crime correspondent, Stewart Tendler (OSM100973).

9.26 On 18 April, the *Portsmouth News* reported that six more people had complained about the treatment of their relatives at the hospital. Hampshire Constabulary described the situation as follows:

> "We have had calls from six people now who have voiced concerns to us. We will be going to see those people to try to clarify what their concerns are … Officers have interviewed a number of medical personnel at the Gosport War Memorial in connection with the initial inquiry, although none was quizzed under arrest or under caution … It remains the case that we have only received one complaint and that everyone who has been questioned has done so voluntarily." (DOH600040, pp1–2)

9.27 The article reported the Trust's position as follows:

> "Operations director Ian Piper earlier told The News the trust had carried out a full internal inquiry into a complaint over the standard of care of the 91-year-old patient. He confirmed: 'No member of staff has been disciplined as a result.'" (DOH600040, p1)

9.28 On 25 July, the *Portsmouth News* reported: *"Senior detectives investigate events surrounding other patient's death. Elderly woman's death: doctors will not be prosecuted."* Detective Superintendent (Det Supt) Jonathon (John) James was quoted as saying:

> "Following the publicity concerning the inquiry into Mrs Richard's death, a number of members of the public contacted us expressing concerns about the circumstances of deaths of relatives at Gosport war Memorial hospital.
>
> We can confirm we are conducting preliminary inquiries to determine whether or not the matters should be subject of a more intensive investigation. That process is more concerned with us assuring ourselves that there is no need to widen the investigation." (DOH603587, p1)

9.29 The report stated that Det Supt James would not reveal how many patients were involved (DOH603587). Mr Piper, for the Trust, was quoted as saying: *"We are reassured that the CPS has not found evidence to pursue a prosecution. We have every confidence in the staff at Gosport War memorial hospital and the care that they provide"* (DOH603587, p1).

9.30 The continuing coverage in the *Portsmouth News* was followed by two other newspaper reports referring to the police investigation: *The Sunday Telegraph* on 29 July and the *Southern Daily Echo* on 30 July (DOH603584).

9.31 On 7 October, the *Southern Daily Echo* reported an exchange between Mrs Mackenzie and Mr Millett:

> "During the Portsmouth Healthcare NHS Trust public meeting held at Fareham civic offices Mrs MacKenzie asked Max Millett, chief executive of Portsmouth Healthcare NHS Trust, to answer her 'many questions' over her mother's death. Mr Millett pledged to answer each of Mrs Mackenzie's questions by letter. He refused to be drawn into a face-to-face discussion."

9.32 On 23 October, the *Independent* reported the decision to set up the Commission for Health Improvement (CHI) inquiry. Two days later, the *Health Service Journal* stated that the inquiry followed two deaths that had already been investigated. It quoted an anonymous Portsmouth

HealthCare NHS Trust spokesperson as saying that the Trust had been *"exonerated"* (DOH900594).

9.33 On 6 November, the *Southern Daily Echo* reported Mr Millett's reaction in these terms:

> "Chief executive Max Millett said: 'We welcome the commission's visit and its review of the service we provide for older people at Gosport War Memorial Hospital. We hope the CHI visit will help reassure people about the care provided today and allow us to demonstrate the progress we have made in service provision over the past two or three years.'"

9.34 CHI Chief Executive Peter Homa said:

> "CHI is undertaking this investigation to look into concerns over the quality and culture of care that patients, who are elderly and particularly vulnerable, have received at Gosport War Memorial Hospital. The findings of our investigation will result in lessons for the whole of the NHS and this is especially important at a time when community and primary care services are undergoing major change." (OSM100617, pp2–3; DOH601570; DOH603422)

Further media coverage: 2002

9.35 On 25 January 2002, the *Independent* reported Mrs Mackenzie's dissatisfaction with both Mr Viggers and Nigel Waterson, the MP for Eastbourne, in whose constituency she lived. This article is described in Chapter 10.

9.36 On 22 April, the BBC reported the case of Alice Wilkie:

> "… the family of Mrs Wilkie say they are angry over the way they claim police handled the investigation.
>
> Speaking about her mother's hospital treatment, Mrs Wilkie's daughter Marilyn Jackson, said: 'She might have had a few more months, she might have had a year, we don't know that.
>
> 'I think she could have had a little bit more care and been better looked after if she'd been somewhere else.'
>
> The family point out that Hampshire Police did not interview relatives and claim the investigation was incomplete. But following their investigations, detectives passed a file to the Commission for Health Improvement (CHI)." (HCO000843, p1)

9.37 The CHI report was published in July. An editorial in the *Portsmouth News* on 4 July read:

> "**War Memorial report is unsatisfactory because it does not bring closure**
>
> We are not looking for scapegoats. We do not say the report into deaths at Gosport War Memorial Hospital is a whitewash. But there is something uncomfortably cosy about it.
>
> Mistakes have been admitted in the provision of drugs to frail old people, yet in no instance, we are told, can we be sure those mistakes were directly to blame for their demise.

> To relatives and other laymen, that will be difficult to believe. And it is with both those groups that we should be primarily concerned now.
>
> Present and future patients are assured that procedures have been changed since the deaths in 1998. But we have to take that on trust, and our trust - both in the system and in individual practitioners - has to be earned afresh.
>
> As for the relatives, they are understandably upset at not having their questions answered in public. We accept there may be good legal reasons for the Fareham and Gosport Primary Care Trust's refusal to engage in a direct public confrontation. There may be cases to come before the British Medical Association.
>
> But we must not forget that the inquiry into the deaths and yesterday's report would never have happened but for the persistence of Gillian Mackenzie, whose mother died at the hospital. We would be happier if the trust had faced allegations more willingly.
>
> And now Mrs Mackenzie says she is still in the dark. So she still cannot draw a line under her personal tragedy.
>
> That is why we say the report is unsatisfactory. It does not achieve closure." (FAM000050, p9)

On the same day, the *Morning Star* reported that *"Probe slams hospital after deaths of elderly patients"*.

9.38 On 3 July, the *Southern Daily Echo* carried two related stories, one headed *"Families Want An Answer"* and the other *"Tears As Hospital Fears Are Unanswered"*. The first article included an interview with Ann Reeves, daughter of patient Elsie Devine, who was quoted as saying*: "We just want some answers. I will not stop fighting until I find out exactly what happened to my mother"* (FAM004269, pp1–3).

9.39 On 8 July, the *Portsmouth News* reported that families were furious when they discovered that hospital staff were being offered counselling because of the findings of the CHI report, while no support had been offered to grieving relatives who had lost their loved ones. The article stated:

> "Families of elderly patients who died at the War Memorial were angered when they read in the Commission for Health Improvement's report that health trust managers had encouraged nurses and doctors to get counselling."

9.40 Some staff who had been stressed by the investigations into a series of deaths at the hospital even complained that they had not been given enough support.

> "But relatives were asking today; 'Where was the support for us?'
>
> Emily Yeats, 26, whose grandmother Alice Wilkie, 82, was one of those who died after going to the hospital for rehabilitation, said: 'What have they offered us? They haven't offered us anything. They've thought to offer the staff counselling but they've left us to it.'
>
> Marjorie Bulbeck, 59, of Southbourne near Emsworth, whose mother Dulcie Middleton, 85, died in the hospital last September, agreed access to an 'independent ear' might have helped.

> 'We have had to push for responses from the health people and to hear they seem to have done more for the staff than us is disappointing.'" (FAM000050, p1)

9.41 The *Portsmouth News* described the week when the CHI report was published as one *"the trust would want to forget"*. Mr Piper had said that staff would have had access to counsellors in line with permanent arrangements for NHS staff across the area. However, he said that he did not feel it appropriate that the Trust should initiate counselling for those with complaints against the NHS, as some people might take this the wrong way. Mr Piper added: *"If any family raised it with us, we would certainly do everything we could to ensure they had access to counselling"* (FAM000050, p1).

9.42 On 11 July, the *Health Service Journal* talked of a *"catalogue of mistakes which had put patients at risk"* under the headline *"Sedative errors missed by trust".* The report said that:

> "… an unspecified 'number' of doctors and nurses working at the hospital have been referred to the relevant regulatory bodies - the General Medical Council and the Nursing and Midwifery Council. But no action has been taken against senior managers responsible for the clinical governance systems in place between 1998-2001." (OSM100688, pp2–3)

9.43 On 23 August, under the headline *"Staff face deaths probe"*, the *Portsmouth News* reported that one doctor and five nurses faced disciplinary hearings in connection with patient deaths at the hospital. The article suggested that one doctor would face a hearing by the Preliminary Proceedings Committee of the General Medical Council (GMC) to decide whether there had been serious professional misconduct. The suggestion was that the five nurses would appear before the Nursing and Midwifery Council to see if they might face similar charges. The article also reported that relatives had been told *"the matter has been referred to the Crown Prosecution Service (CPS) again"* (FAM000050, p3).

9.44 On 12 September, the *Portsmouth News* carried a further story under the headline *"Families blast police over deaths inquiry"*. The article stated:

> "Relatives fighting to find the truth about the deaths of their parents at a Gosport hospital say the police are still letting them down … when the cases were pursued by the police they rounded on officers saying they had not done their job properly."

The article quoted Mrs Mackenzie: *"If the entire report has been sent to the CPS hopefully they will go back to the police and say that more investigation is needed"* (FAM000050, p10).

9.45 On 14 September, there was some local and national media coverage of the news that Sir Liam Donaldson, the Chief Medical Officer, had appointed Professor Richard Baker to conduct a clinical audit. There was a report in *The Telegraph*, while *The Guardian* stated:

> "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. Officials stressed that inquiries of this kind are very unusual." (DOH000169, p3)

9.46 The *Guardian* article continued: *"Sir Liam's decision to mount an inquiry 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'"* (DOH000169, p3).

9.47 On the same day, the *Portsmouth News* published an editorial headed *"Time to end the doubt over deaths"*, which welcomed Sir Liam's intervention and stated:

> "Imagine you are one of the relatives who have complained long and loud about how elderly patients have been treated at Gosport war memorial Hospital.
>
> You've already suffered the grief of losing a loved one and believe there are disturbing questions surrounding the nature of their death.
>
> Angry and upset you make a complaint and expect some answers.
>
> But time moves on and two inquiries prove inconclusive.
>
> A police report can't establish whether any crimes have been committed. One by independent watchdog, the Commission for Health Improvement, criticises over-use of potentially lethal drugs.
>
> But still there is nothing to link procedural problems with any deaths.
>
> All the while the allegations have dragged on – since 1998 – a cloud of uncertainty has hung over the hospital.
>
> Families' suspicions have deepened and everybody who might use a hospital that serves 100,000 people has been left wondering what's really been going on behind its doors.
>
> Staff insist that nothing untoward has ever happened while relatives are adamant that is not the case. But what are people to believe?" (OSM100946, p1)

9.48 The *Portsmouth News* suggested that:

> "If there has been no wrongdoing, the professor [Baker] conducting the investigation must say so and allow confidence in the hospital to return.
>
> If there is any evidence of staff being in any way responsible for elderly patients' deaths, then that too must be made public and acted upon.
>
> After so long waiting and wondering, only definitive answers will do." (OSM100946, p1)

9.49 On 15 September, Lois Rogers, *The Sunday Times*' medical correspondent, reported that 13 deaths were being investigated. She linked the issue to the prosecution of Dr Shipman. The article said that the problem was related to the use of diamorphine and named Dr Jane Barton as the doctor under investigation:

> "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." (DOH000169, p2)

9.50 Lois Rogers' article explained the background in these terms:

> "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." (DOH000169, p2)

9.51 The article published in *The Sunday Times* did not include material from a conversation that the reporter had with Tim Barton, Dr Barton's husband. The Panel has seen the record of that conversation (HCO116285).

9.52 As with the earlier reports in the *Portsmouth News*, the article in *The Sunday Times* had an impact. The following day, as Chapter 4 shows, Staff Nurse Anita Tubbritt and Nurse Beverley Turnbull handed over to an NHS manager a folder of documents dating from 1991/92 ('the nurses' dossier'), covering the nurses' concerns described in Chapter 1 of this Report.

9.53 On 15 September, the *News of the World* reported the story (DOH000169, p2). Sky News also covered it, making a link to Dr Shipman. There were articles in *The Times* the following day (OSM100970) and in the *Daily Mirror* (OSM100756) two days later, together with reports in local newspapers in Newcastle and Liverpool. The *Portsmouth News* published an article on 18 September saying that Dr Barton was under investigation (OSM100934). On 19 September, the *Health Service Journal* also linked Professor Baker's appointment to the Dr Shipman investigation (OSM100688).

9.54 On 20 September, the *Portsmouth News* reported that Mr Piper and Tony Horne, Chief Executive of East Hampshire Primary Care Trust, had been temporarily redeployed. Describing the move as a *"startling development"*, the newspaper linked it to the discovery of *"a new file about the use of drugs"* at the hospital in 1991, implying that the two men had been moved because they had been involved in management decisions at the time (OSM100936).

9.55 One theme of press interest in the period was the appointment of Ann Alexander, who had taken up the case of the Shipman families, as the solicitor for some of the families who had previously had relatives in the hospital. The *Portsmouth News* covered this appointment on 23 September 2002 (APA000164).

9.56 The *Portsmouth News* ran a two-page feature with a front cover picture on Mrs Mackenzie in their weekend supplement. Headed *"Why did my mother die? The OAP who won't stop fighting until she's found the truth"*, the feature described Mrs Mackenzie's long fight to get an explanation for her mother's death (FAM000050, pp25–8).

9.57 On 27 September, the *Southern Daily Echo* reported:

> "HEALTH bosses have not ruled out cuts to health services across Fareham and Gosport as they struggle to make up a GBP 500,000 deficit. The bleak financial outlook is revealed just days after Fareham and Gosport's beleaguered primary care trust lost its chief executive, Ian Piper."

9.58 On 3 October, the *Southern Daily Echo* published a story under the headline *"More cases in Gosport wards probe"*, suggesting that more cases had been uncovered. The article stated:

> "Ms Alexander, the solicitor who represented more than 300 relatives in the Harold Shipman inquiry, said since launching the group more people have come forward.
>
> We are going to be investigating some eight new claims concerning treatment of elderly patients while at Gosport War Memorial Hospital. These have come in as a result of the forming of the action group and will be investigated by our team." (HCO000819, p2)

9.59 On 11 October, the *Portsmouth News* ran three articles: one headed *"Probe GP back at work"* (OSM100933, p1), another headed *"Colleagues Support GP"* (OSM100929) and a third saying that Dr Barton was not going to face any criminal charges:

> "The News understands the GMC, which has only ever formally confirmed it is 'aware' of Dr Barton, has decided she is not a danger to patients and is fit to continue working while it examines her past performance.
>
> The GMC refused to verify that it was happy for Dr Barton to continue to work while she waited for a date for a possible conduct committee hearing.
>
> However, Adrian Osborne, from Hampshire's strategic health authority said; 'The GMC has not advised the strategic health authority of any grounds on which it believes it would be appropriate to prevent Dr Barton from working in general practice. On this basis we believe it is appropriate for Dr Barton to continue.'" (OSM100933, p1)

9.60 On 22 October, the *Portsmouth News* reported that *"Ten more families have asked police and Health officials to look into the deaths of their relatives at the Gosport War Memorial Hospital"*. It added: *"Many of these concern the administration of sedative drugs, such as diamorphine. The report quoted the police as confirming that ten relatives had made contact"* (OSM100932, p1).

9.61 On 3 and 4 November, Sky News carried two broadcasts interviewing Mrs Reeves, highlighting the case of patient James Ripley and covering the family press conference organised by Ann Alexander. On 5 November, the *Daily Mirror* (OSM100757), *The Sun* (OSM100961), the *Independent* (DOH000148, p3) and the *Birmingham Post* reported that 50 families had complained about the treatment of their relatives. The *Independent* reported the setting up of an NHS helpline for people to contact the health authority, which had led to between *"40 and 50 people"* making contact (CPS000934).

9.62 On 7 November, *The Times* carried an article, *"Shipman style inquiry into 50 deaths at hospital"*. The article referred to a meeting Ann Alexander had had with Det Ch Supt Watts (he had been promoted) and Detective Inspector (Det Insp) Nigel Niven in Manchester to discuss how the Shipman investigation could aid them. The article quoted Ann Alexander: *"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" (DOH000148, p1).

9.63 Andrew Pate, a reporter with Meridian TV, requested an interview with Hampshire Constabulary. The meeting took place on 10 December and was attended by Mr Pate, Det Insp Niven, Det Ch Supt Watts and Detective Sergeant (Det Sgt) Owen Kenny. Det Insp Niven sent Mr Pate a record of the meeting. Under the headline *"re Operation Rochester – Proposed Documentary"*, the record shows that the police sought to dissuade Mr Pate from making a documentary on the subject, at least at this stage:

> "You will recall that during this meeting you outlined to us your thoughts concerning the investigation into the Gosport War Memorial Hospital and that you were considering making a documentary. Mr Watts then raised certain issues concerning the Police perspective of such a documentary being made and the impact that the potentially adverse effect could have on the investigation.
>
> Having heard what was said you agreed not to pursue the project at this time. In addition, you agreed not to provide regular updates with regard to the investigation by virtue of interviewing potential witnesses.
>
> It was, however, of course accepted by the Police that it was only right that you broadcast actual 'news' about the matter in general." (HCO004543, p2)

9.64 Mr Pate has told the Panel that he has no recollection of receiving this letter. On 13 January 2004, he sought an interview with Det Ch Supt Watts *"or another Hampshire Police representative over the next few weeks"* (HCO502394, p1). There is no record available to the Panel of any reply to Mr Pate. There is a record of Hampshire Constabulary agreeing in January 2007 to conduct an interview with Mr Pate, following the completion of the police investigation (HCO002569).

9.65 On 20 November, the *Portsmouth News* reported that Mr Viggers had visited the hospital to meet patients and staff and show his support. This is covered in Chapter 10.

Further media coverage: 2003–08

9.66 The story was taken up again on 11 February 2003, when BBC Radio 4 broadcast a programme in its *File on 4* series which examined the allegation that the lives of elderly patients were being shortened by their treatment. This programme included an interview with Mr Viggers and is covered further in Chapter 10.

9.67 On 25 May, Lois Rogers published an article in *The Sunday Times* headed *"Police probe into 62 deaths at hospital"*. The article stated:

> "Police sources confirmed this weekend that officers were investigating 62 deaths over four years. Dozens of nursing and medical staff are being interviewed.
>
> … Last week the Gosport families were invited to a meeting later this summer to update them on the progress of the inquiry. Many are angry that the police and health authorities have persistently failed to investigate their complaints fully.

> Ann Reeves, whose mother Elsie Devine died in suspicious circumstances at Gosport at the same time as Richards, said the police had originally told her it was 'not in the public interest' to investigate.
>
> Last week she said: 'We do all hope this criminal investigation is now going somewhere and that we will get some answers. It has been a nightmare for the families.'" (OSM100950, p1)

9.68 On 11 June, the *Southern Daily Echo* carried a report headed *"Inquiry demanded into hospital deaths":*

> "At a press conference staged by a legal firm which is representing 27 families, solicitor Ann Alexander confirmed they would be pressing for a full and thorough investigation.
>
> She said: 'We would not rule out calling for an inquiry from any agency but I understand the police are currently reinvestigating complaints and I will be meeting with them later this week.'
>
> At the press conference held this morning it was also revealed that 30 more concerned relatives have complained to Hampshire police regarding the care their loved ones received while recuperating at the cottage hospital during the late 1990s."

9.69 Around this time, Gosport War Memorial Hospital was beginning to be linked to other hospital investigations into the care of the elderly. A short article in *The Guardian* on 24 September linked it with cases in Withington Hospital, Manchester and North Lakeland Healthcare NHS Trust.

9.70 On 7 January 2004, the *Portsmouth News* reported a police statement. Under the headline *"Sensitivity, reassurance and a proper explanation are needed over death"*, its editorial read:

> "Two differing sentiments stand out in the welter of comments today on disquiet surrounding the progress - or lack of it - of police investigations into the deaths of scores of elderly people at Gosport War Memorial Hospital.
>
> The first is from the police officer in charge of the inquiry. 'The families must be confident that there has been a thorough investigation,' he says.
>
> The other is a woman whose mother died at the hospital five years ago. 'I have very little confidence in what is going on at present,' she says.
>
> Therein lies a gulf that must be bridged - and the driving force for that should logically be the police.
>
> Of course, an inquiry into the deaths of more than 60 people will have to be laboriously painstaking. It cannot, it must not, be rushed.
>
> As senior officers point out, it draws in experts who cannot shelve everything else at the drop of a hat to give immediate opinion on potential evidence presented by police investigators.
>
> But a need for sensitivity is writ large here. Police are dealing with relatives who have lost loved ones and are desperately seeking answers. The fact is that, in this case, the inquiry is following an earlier unsuccessful probe, the efficiency of which is now subject to official investigation.

> No-one has voiced to The News any fear that antagonism over that might have led to a strain in relations between police and families. But the time is ripe for senior officers to offer reassurance and an explanation acceptable to relatives who seek only the full truth about what happened to a loved one." (HCO000827, p4)

9.71 In the course of 2004–06, national media coverage specific to the hospital was very limited.

9.72 More intensive media coverage occurred with the completion of the police investigation. On 20 December 2006, the *Portsmouth News* reported the decision that there would be no prosecutions, and followed this up with two articles the following day. On 21 December, the newspaper carried an interview with Assistant Chief Constable (Asst Ch Const) Watts under the headline *"Top cop defends deaths inquiry"*. The article reported Asst Ch Const Watts' comment that he was not surprised there was to be no prosecution (MRE000495).

9.73 In a separate article, the *Portsmouth News* reported relief among Dr Barton's GP colleagues. The article also contained these comments from an unnamed nurse:

> "She told how staff had to put up with taunts from some visitors throughout the investigations, which first began in 1998. She told how hospital bosses had to call a crisis meeting to advise nurses and staff to ignore it.
>
> … People would ask if you were one of the nurses who killed the patients. They said people came to our hospital to die.
>
> People just assumed that there couldn't be all that smoke if there was no fire. The morale was low - it is not nice as a nurse to hear that sort of thing. They had a meeting and we were just told to ignore it. But we all stuck together. We knew that we had not done anything wrong. I am sure there must be enormous relief in the hospital this week." (MRE000496, pp1–2)

9.74 Other newspapers reported the decision. The *Yorkshire Post* said: *"Yesterday, the CPS announced that negligence could not be proven to a criminal standard and that there was no realistic prospect of conviction of healthcare staff."*

9.75 At the same time, the story was overtaken in the national media by Department of Health Ministers announcing that the hospital was one of six to get extra funding (over £6 million) for improvements. This story made the national press, including *The Guardian*. The decision not to prosecute staff at the hospital did not.

9.76 On 14 May 2008, the inquests into the deaths of ten people who died at the hospital were formally opened and then adjourned. That day a report in the *Portsmouth News* named the ten (OSM100791).

9.77 Four days later, Lois Rogers followed up her earlier articles in *The Sunday Times*. Under the headline *"Convalescent unit faces inquest into suspicious deaths"*, she suggested that the Secretary of State for Justice, Jack Straw, had ordered the inquest:

> "Straw has demanded the coroner's investigation even though at least seven of the bodies were cremated. An inquest cannot take place in the absence of a corpse unless there are exceptional circumstances.

> The justice ministry believes there is sufficient anxiety about the circumstances of the cases to require such a procedure, which, in the absence of remains, will be based only on a review of medical records and witness statements.
>
> The allegation of 'murder by euthanasia' is similar to that levelled against Harold Shipman, the GP from Greater Manchester who was Britain's biggest mass killer. He was convicted of 15 murders but is believed to have killed about 250 of his patients. Shipman committed suicide in prison in 2004.
>
> … The inquest into the 10 selected Gosport deaths was opened last Wednesday at Portsmouth and South East Hampshire coroner's court.
>
> A full hearing is scheduled for this autumn. A different coroner, Andrew Bradley, from Basingstoke, will conduct the process, which is expected to be the largest inquest of its kind." (MRE000484, p1)

9.78 The article in *The Sunday Times* quoted a spokesperson for Hampshire Primary Care Trust as saying that recommendations for improvements in the hospital's practice had already been implemented. She pointed out that the police investigations had come to nothing, and that *"the further scrutiny was 'hugely distressing' for staff"* (MRE000484, p2).

Further media coverage: 2009–10

9.79 Local and national media coverage of the hospital intensified in the course of 2009 as the inquests began and the GMC pursued the question of Dr Barton's fitness to practise. Media comment became more critical of the hospital and the investigative processes and more in tune with the dissatisfaction expressed by bereaved relatives of patients at the hospital. This would prove to be a transition to a period of growing demand for some form of independent inquiry.

9.80 The inquests into the ten deaths began on 18 March 2009 and received local and national coverage in the press and on television. This included coverage by BBC *South Today*, which was to go on to receive an award from the Royal Television Society.

9.81 On 15 March 2009, the *Independent on Sunday* published a comprehensive account of the events that led to the inquests and a timeline. An article by Nina Lakhani focused on the GMC and its decision-making process when dealing with Dr Barton:

> "The Government has so far rejected relatives' calls for a public inquiry into the deaths, despite stinging criticisms about the way they were handled by the police and the General Medical Council (GMC). Three police investigations have failed to shed light on why the patients died. The GMC, in particular, has been lambasted by the relatives for its failure to act promptly and decisively.
>
> … The GMC has attracted bitter criticism for the way it has handled this case, particularly the length of time it took them to take action. Dr Jane Barton, the only doctor investigated in relation to the case, was ordered last July to stop prescribing morphine, many years after the matter was drawn to the GMC's attention.
>
> At least one relative of the dead wrote to the GMC in 2002, expressing her concerns about Dr Barton and asking the GMC to investigate. In reply on 11 June 2002, the GMC said: 'We do not consider that the actions of Dr Barton raise any issue which could be regarded so serious as to justify formal proceedings which may result in

> the restriction or removal of her registration.' Yet two months after the inquest was announced last year, Dr Barton's practice was restricted by the GMC. A fitness to practice hearing will begin after the inquest.
>
> In GMC correspondence seen by The Independent on Sunday, it admits it was aware of the case in 2000, but repeated attempts by GMC lawyers between 2000 and 2004 to persuade the Interim Orders Committee to take action against Dr Barton were unsuccessful. The committee was not convinced of the need to restrict Dr Barton's practice until the inquest was announced.
>
> … Ann Alexander, the solicitor who represented families in the Harold Shipman inquiry and advised a number of relatives in the Gosport deaths, said: 'The GMC has made few improvements since the publication of the Shipman inquiry. I do not understand why they failed to impose restrictions on the doctor until 2008. The GMC must remember that its role is to protect patients and not doctors.'
>
> According to the GMC, its actions were held back while other investigations took place, but says the necessary steps to investigate the case fully are being taken. A GMC spokeswoman said: 'This is a difficult and complex case which has been investigated by various agencies. Criminal investigations always take precedence over any GMC procedures. It was necessary [for us] to wait for the outcome of the various investigations.'" (PCO001063, p3)

9.82 On 19 March, the Press Association ran a story on how one patient's son was treated, under the headline *"Hospital gave death news coldly, son claims".* The report read:

> "Elsie Lavender, a widow from Gosport, suffered a stroke in early 1996 and was initially treated at the Royal Naval Hospital Haslar before being transferred to the GWMH on February 22, 1996.
>
> The 83-year-old suffered from diabetes for 50 years and, as well as the stroke, she suffered a head injury in a fall down the stairs at her home.
>
> Her son Alan Lavender told the inquest that he understood that his mother was transferred to Daedalus stroke rehabilitation ward at GWMH for rehabilitative care. But he added he was shocked when Dr Jane Barton told him in a 'callous' manner that his mother 'had come to the hospital to die'." (OSM100818, p1)

9.83 ITN flagged up the inquiry and BBC South ran regular reports. For example, *ITV News Meridian* ran a number of reports on the inquests. The press coverage brought out a number of the issues. These included the nurses' dossier and reference to Robert Wilson's last words to his son, *"Help me son, they're killing me"* (IDP100065, pp18–19).

9.84 The coverage of the outcome of the inquests focused on the families' demands for a public inquiry. The Press Association headline was *"Relatives demand public inquiry into hospital deaths"*, with an accompanying article, *"Hospital labelled death ward"*.

9.85 The *Independent* reported that the inquest had firmly criticised the hospital. Under the headline *"Morphine overdoses blamed for hospital patients' deaths"*, the newspaper's health editor described it as an *"unprecedented inquest"* (GMC101233, p202).

9.86 The Press Association reported:

> "Dr Jane Barton, who works as a GP, said in a statement: 'I have always acted with care, concern and compassion towards my patients. I am pleased the jury recognised that in all of these cases, drugs were only given for therapeutic purposes.'" (OSM100964, p1)

9.87 The Press Association further reported:

> "Richard Samuel, director of performance and standards for NHS Hampshire which has inherited control of GWMH, said: 'It is a matter of regret to the NHS that three verdicts indicate that in the mid/late 1990s the medication administered to these (five) patients has been found to have contributed to their deaths.
>
> NHS Hampshire will be now be contacting these families but I would also like to take this opportunity to apologise to the families concerned on behalf of the NHS for any treatment or care which has been found to have contributed to the deaths of their loved ones.'
>
> He added that systems at the hospital had been overhauled to meet the 'highest standards'.
>
> 'Since the late 1990s the systems and policies in place at Gosport War Memorial Hospital have undergone a complete overhaul.
>
> I can assure the families and local people that all the issues highlighted by these inquests have been addressed and the care at Gosport War Memorial Hospital today is of the highest standard.'
>
> In a statement, Hampshire police said it was not considering re-opening its investigations.
>
> A spokesman said: 'It is our genuine hope that the extensive nature of the investigations conducted, the findings of the Crown Prosecution Service and now that of HM Coroner provide those involved with some resolution if not comfort for the loss of loved ones.'" (OSM100964, p1)

9.88 On 5 April, Nina Lakhani ran a story in the *Independent on Sunday* entitled *"Gosport deaths 'not important enough' to justify public inquiry"*. The article referred to *"The Betrayed"* and the newspaper called for an independent public inquiry. The *Independent on Sunday* suggested that the coroner and an unnamed senior police officer had put pressure on the Department of Health to hold a public inquiry two years previously:

> "Officials from the Ministry of Justice and the Department of Health refused petitions from a coroner and a senior police officer for a public inquiry in August 2007, according to confidential emails seen by The Independent on Sunday.
>
> But the DoH claimed yesterday that a public inquiry into the deaths at Gosport War Memorial Hospital was refused on the grounds that it would duplicate work done, or under way, by the police and health regulators – a claim rejected by relatives and lawyers.

> Several emails from the Portsmouth and South East Hampshire coroner reveal his concern at the Government's decision to refuse a public inquiry into all 92 deaths and instead authorise inquests into just 10.
>
> … In an email last November to a relative of one of the dead, the coroner, David Horsley, wrote: 'Hampshire Police, Hampshire County Council and I all tried to persuade the Government to hold a public inquiry into the deaths but there was no interest whatsoever. Neither was the Government prepared to assist with any additional funding for the inquests.'
>
> In another email, Mr Horsley said: 'We did try very hard in the public inquiry direction but without any success, despite a face-to-face meeting at the Ministry of Justice in London. The reason for the refusal was that there were no matters of national importance involved.
>
> Prior to that, I tried to pursue with the CPS why no prosecutions were being undertaken. I understand the CPS decided not to prosecute on the advice of leading counsel. I did ask the CPS for sight of counsel's advice on a number of occasions but they declined to let me see it.'" (GMC000112, pp1–3)

9.89 The article also described how the Coroner had refused to allow some detailed medical evidence at the hearing, and referred to demands for an inquiry:

> "John White, a solicitor from law firm Blake Lapthorn, is urging the other 82 families to come forward. He said: 'Until the authorities really understand and acknowledge what went on in Gosport, the families are bound to be left with feelings of injustice, anger and mistrust. Public inquiries were held in the cases of Shipman, Beverley Allitt, Alder Hey and Bristol, which all happened around the time of Gosport. Why then does Gosport not merit a public inquiry?'" (GMC000112, p4)

9.90 On 15 May, the *Independent* reported that Dr Barton would now face a disciplinary hearing: *"Doctor to face hearing over patient deaths; GP could be struck off register over prescription of 'excessive' drug doses"* (MRE001476, p1).

9.91 On 24 May, Nina Lakhani reviewed the deaths at the hospital in a 2,438-word feature for the *Independent on Sunday*, under the headline *"Help me son, they're killing me"*. The article traced the story back to 1991, when nurses first alerted hospital staff to their concerns, and linked the events at the hospital with other NHS cases:

> "The deaths at Gosport happened around the time of several scandals involving NHS doctors and nurses. In 1993, Nurse Beverly Allitt was convicted of murdering four children at a Lincolnshire hospital. At least three babies died in the Bristol baby scandal between 1991 and 1995, and more than 2,000 organs were illegally harvested at Alder Hey Children's Hospital between 1988 and 1995. The GP Harold Shipman was convicted of 15 murders in 2000 but a public inquiry found evidence to say he killed at least 250 patients." (IDP100065, pp18–19; PCO001062, p5)

9.92 Nina Lakhani's article suggested that there may have been a cover-up, possibly for political reasons:

> "The consensus among the bereaved families who have spoken out is that there has been a cover-up about what happened at Gosport. They are unhappy with the way their complaints have been dismissed, delayed or inadequately investigated.

> Relatives believe the deaths were downplayed because another NHS scandal would cause public outrage and may have had political consequences." (IDP100065, p19; PCO001062, p5)

9.93 The same article highlighted the failure to publish the findings of Professor Baker:

> "No one - apart from the Government and the GMC - has set eyes on a crucial study by Professor Richard Baker into whether the death rate at Gosport was abnormally high. Other highly critical medical opinions were withheld from the jury by the coroner at the inquests. And the Government rejected pleas from the coroner to hold a public inquiry into all of the deaths rather than inquests into just a few. The children of Arthur Cunningham, Stanley Carby, Robert Wilson and Norma Windsor, who died between 1998 and 2000, have all been advised by the authorities to 'move on' and accept that their parents were old and sick - but none is prepared to. They feel let down: by the NHS, police, Crown Prosecution Service, GMC, coroner and the Government. They believe the public deserves the truth and that justice must be done, for their parents, but also for everyone else who has, or will have, an elderly relative in hospital. Because if things go wrong, horribly wrong, the truth should not be hidden - no matter how much it hurts." (IDP100065, p19; PCO001062, p5)

9.94 As Chapter 6 describes, the GMC's fitness to practise hearing began on 8 June. The coverage was detailed and graphic. The Press Association reported *"Elderly Patients left in Drug-Induced Comas, Hearing Told"* and *"Accused Doctor Prescribed Drugs to 'Keep Patient Quiet'".*

9.95 On 9 June, *Metro* ran an article titled *"Doctor: I drugged patients"* (GMC000498, p3). A 1,255-word Press Association article was headed *"Mother fell unconscious after painkillers, daughter tells panel". The British Medical Journal* reported on 13 June that *"GP admits prescribing painkillers to patients in 'too wide a range'"* (GMC000220, p2).

9.96 On 8 July, *The Telegraph* reported the expert advice of Professor Gary Ford under the headline *"Doctor shortened patient's life with drug cocktail, says expert; accused of hastening death of elderly patient in hospital"*:

> "'When you increase a dose of opiates there's the risk of developing significant adverse effects – respiratory depression or reduced conscious level,' Prof Ford said.
>
> 'I can't see how it is consistent with good medical practice. I can't see how it is in the best interests of the patient to have the opiates prescribed. This man is dying, there is little doubt about that, but the treatment he is receiving as a dying man should still be appropriate to his need.'" (GMC000078, p2; GMC000079, pp1–2)

9.97 The completion of the GMC's fitness to practise hearings was accompanied by extensive coverage in the media, including in the *Daily Mail* and *The Telegraph*. The Press Association's headline was *"Doctor facing disciplinary action over drugs prescriptions"*. As Chapter 6 explains, the GMC sanctions proceedings began in January 2010.

9.98 Media coverage anticipated the outcome of the sanctions proceedings and growing pressure for some form of public inquiry.

9.99 On 17 January 2010, under the headline *"Doctor linked to 92 patients' deaths faces being struck off"*, *The Sunday Telegraph* reported:

> "A DOCTOR at the centre of a police investigation into the deaths of nearly 100 elderly patients faces being struck off the medical register for prescribing excessive doses of painkillers … Should Dr Barton now be struck off, campaigning families will use it as leverage to press for a public inquiry into events at the hospital during the 1990s." (GMC000100, p2; GMC000101, p1)

9.100 On 20 January, the Press Association reported that *"Doctor 'overprescribed' drugs for elderly patients"*. The article continued: *"A doctor who prescribed 'potentially hazardous' levels of drugs to elderly patients should be struck off, the General Medical Council heard today"*.

9.101 On 24 January, the *Independent on Sunday* reported:

> "MPs will demand this week a public inquiry into the suspicious deaths of scores of elderly patients at Gosport War Memorial Hospital. An early-day motion calling for an independent inquiry 'with equivalent powers to the Shipman inquiry' into the treatment of patients at the Hampshire hospital between 1989 and 2000 was tabled by Liberal Democrat health spokesman, Norman Lamb, on Friday; MPs can register support for the motion from tomorrow. It comes days before the fate of Jane Barton, the doctor at centre of the allegations, is decided at a General Medical Council hearing." (OSM100957, p1)

9.102 As Chapter 6 explains, the Fitness to Practise Panel gave its determination on sanction on 29 January. Anticipating the outcome, ITN reported: *"A doctor faces being struck off by the General Medical Council for prescribing 'potentially hazardous' levels of drugs."*

9.103 When the outcome became known, the media focused on the anger of relatives that Dr Barton had not been struck off. The Press Association reported *"Anger as drug errors doctor free to practice"* and continued:

> "Families reacted with disgust today after a doctor who put their elderly relatives at risk of death by prescribing 'potentially hazardous' levels of drugs escaped being struck off.
>
> Dr Jane Barton was found guilty of serious professional misconduct by a Fitness to Practise Panel at the General Medical Council (GMC) after a series of failings in her care of 12 patients at the Gosport War Memorial Hospital in Hampshire between January 1996 and November 1999.
>
> The panel found she made a catalogue of failings in her treatment of the patients, who later died, including issuing drugs which were 'excessive, inappropriate and potentially hazardous'.
>
> Panel chairman Andrew Reid said: 'The panel has found proved that there have been instances when Dr Barton's acts and omissions have put patients at increased risk of premature death.'
>
> But relatives of the elderly patients left the hearing in disgust on learning that the doctor will be allowed to continue working if she abides by certain conditions.
>
> Iain Wilson, from Gosport, whose 74-year-old father, Robert Wilson, was one of the patients, shouted at the panel: 'You should hang your head in shame.
>
> You haven't done anything at all to protect the public.'"

9.104 The Press Association further reported Dr Barton's statement:

> "'I am disappointed by the decision of the GMC panel but appreciate that in imposing conditions, they recognised the great difficulties and unreasonable pressure under which I had to work.
>
> Anyone following this case carefully will know that I was faced with an excessive and increasing burden in trying to care for patients at the Gosport War Memorial Hospital.
>
> I did the best I could for my patients in the circumstances until finally I had no alternative but to resign.'
>
> She maintained that 'given the situation, my general practice and procedure were perfectly reasonable' and said none of the consultants ever expressed concern about her working practices.
>
> She continued: 'Throughout my career I have tried to do my very best for all my patients and have had only their interests and wellbeing at heart.'"

9.105 Other national media coverage included reports in *The Guardian* and the *Daily Mirror*. The *Daily Express* headline was *"Outrage at let-off for doctor linked to 12 drug cocktail deaths"* (GMC000104, p2). The *Independent* covered the story under the headline *"Outcry as doctor escapes ban after inquiry into 'death wards'"* (GMC000104, p2).

9.106 The outcome was also covered in regional newspapers, including *The Yorkshire Post*. *The Newcastle Journal* reported *"Families' Fury Over GMC Doctor Ruling"*.

9.107 The *Independent on Sunday* returned to the subject on 31 January. Nina Lakhani reported a fresh challenge to the Government over the GMC's decision not to strike off Dr Barton. Under the headline *"Outraged families will ask the High Court to rule on the General Medical Council's refusal to strike off Dr Jane Barton"*, the article referred to the action families intended to take (IDP100003, p7).

9.108 The *Independent on Sunday* article quoted Mr Lamb:

> "Norman Lamb, the Liberal Democrat health spokesman, who last week tabled an Early Day Motion calling for an independent public inquiry into the Gosport deaths, said last night: 'The failure of the system to deal with the Dr Barton case speedily has helped her to convince the panel she is safe to practice and should stay on; it beggars belief that she has been permitted to do so. There is real concern about the inconsistency of decisions made at these hearings, which completely undermines faith in the system's ability to protect patients.'" (IDP100003, p9)

The *Independent on Sunday* article also quoted Labour MP Jeremy Corbyn, who had supported the Early Day Motion: *"Part of the reason we are calling for a public inquiry is that it would send out a message to all health workers and services that NHS patients should get the best possible care regardless of age"* (IDP100003, p9).

9.109 The *Independent on Sunday* article pointed out that the local MP, Sir Peter (Mr Viggers had been knighted in 2008) had repeatedly rejected calls for a public inquiry (IDP100003, p9). Chapter 10 covers the role played by Sir Peter.

9.110 Further media coverage reported the reaction to Dr Barton's resignation as a GP. On 30 March, the Press Association stated *"Doctor at centre of deaths probe retires"* and continued:

> "Mike PORTER, Head of Practice at Forton Medical Centre, said 'We are sorry to see her go, she was very well supported by the doctors and the staff here.
>
> As far as I am aware, Jane has retired and that is it. When GPs retire they have the option to come back to work at the same practice but she has not asked us to come back.'
>
> Families of some of those who died at the hospital reacted with disgust at the GMC ruling which is currently being reviewed by the Council for Healthcare Regulatory Excellence (CHRE) which monitors the work of health regulatory bodies." (GMC000034, pp1–2)

9.111 A few days later, on 4 April, the *Independent on Sunday* reported Sir Peter's decision not to stand for Parliament again:

> "Gosport MP and garden-proud Peter Viggers whose expense claims included £1,645 for a floating duck house for his pond, more than £3,000 for gardening over three years and £500 for manure. His failure to make representations for the families seeking answers about the deaths of elderly patients at Gosport War Memorial Hospital has impeded their long fight for justice." (IDP100065, p7)

9.112 Further limited media coverage in 2010 focused on the decision of the CPS not to bring criminal charges against Dr Barton, following the inquests and the GMC proceedings.

9.113 On 18 August, the Press Association reported the reaction of Hampshire Constabulary and of the families:

> "Assistant Chief Constable David Pryde said: 'This has been an incredibly complex and challenging investigation for all involved, given that many of the patients who died in hospital were manifestly unwell and suffering some of the more severe problems in geriatric medicine.
>
> We understand that this may not be the outcome families were hoping for, but I would like to reassure them and the general public that every investigative opportunity has been fully explored.
>
> Hampshire Constabulary has committed significant resources into this investigation to ensure that a complete and impartial inquiry was conducted.'
>
> Ann Reeves, 56, daughter of Elsie Devine, one of the patients who died at the hospital, said she would campaign for a judicial review of the CPS decision and is considering a private prosecution against Dr Barton.
>
> She said: 'This decision is totally inconceivable. It's been 11 years. I'm angry and disgusted. I'm devastated for my mother and the way she lost her life.
>
> We are not in shock; we are very, very angry and trying to take it all in.
>
> We are looking at getting a judicial review and if not we are going to get her into a criminal court with a private prosecution.'" (GMC000027, p2)

9.114 On 19 August, *The Telegraph* briefly reported the story (GMC000026, p2).

9.115 On 2 September, the Press Association covered a protest march of 30 people, led by Mrs Reeves, to hand in a petition at 10 Downing Street (GMC000038, p1).

Media coverage from 2011 to the announcement of the Gosport Independent Panel

9.116 On 10 April 2013, the Press Association ran a long report covering the inquest into the death of Gladys Richards. Under the headline *"Drugs ensured my mother's death"*, the Press Association reported:

> "The daughter of an elderly woman who died at a heavily criticised hospital nearly 15 years ago has said her mother was 'condemned to death' by the medication she was given.
>
> Gladys Richards, 91, was taken to Gosport War Memorial Hospital (GWMH) in Hampshire in August 1998 for recuperation from a hip operation after she had a fall.
>
> But after she suffered a haematoma (bruised blood), Mrs Richards, of Lee-on-the-Solent, Hants, was given diamorphine administered through a syringe driver (a device which continuously administers drugs) and died five days later on August 21 1998, the hearing was told." (SOH100686, p1)

9.117 Four days later, the Press Association reported the hospital's defence under the headline *"Woman, 91, given pain medication"*:

> "The clinical manager at a heavily-criticised hospital where an elderly patient died nearly 15 years ago has told an inquest that she was given medication to help ease her pain in her final days after her condition deteriorated.
>
> Philip Beed, a nurse in charge of the Daedalus ward at the Gosport War Memorial Hospital (GWMH), said that when patients such as Gladys Richards were placed on syringe drivers, a device which continuously administers drugs, they were likely to die."

9.118 Local media also covered the inquest. On 11 April, under the headline *"Doctors disagree over use of drugs"*, the *Southern Daily Echo* reported:

> "Dr Richard Reid, a consultant then at Queen Alexandra Hospital in Portsmouth, said, on the basis of medical guidelines and that Mrs Richards was described in the medical notes as still in pain, the dose given to Mrs Richards 'feels entirely appropriate.'
>
> He said Mrs Richards' survival for a further four days after it was administered told him that increasing the dosage was 'unlikely to have been responsible for her demise'.
>
> However, Professor Robin Ferner, a consultant physician and clinical pharmacologist from Birmingham University, told the Portsmouth inquest that while it was right to ensure that patients were not in pain, it might have been achieved with 'substantially lower doses'.

> Prof Ferner said it was 'very likely' that giving diamorphine by injection alongside other drugs 'rendered Mrs Richards too drowsy to take oral fluids, increased the risk of her developing renal failure and hastened her death'.
>
> He said he also found it difficult to explain, given the absence in the records, why there had been a switch from oral to injected medication." (SOH100664, p1)

9.119 On 18 April, the Press Association reported the outcome of the inquest into the death of Mrs Richards. Under the headline *"Medication 'a factor' in death case"*, the Press Association stated: *"A coroner has ruled that medication given to an elderly patient at a heavily-criticised hospital contributed 'more than insignificantly' to her death"* (GMC000540, pp3–7).

9.120 Further media coverage was prompted by the publication in August of Professor Baker's report, nearly ten years after he had completed it. The Department of Health's press release stated: *"Professor Baker made 5 recommendations in his report. These have been largely overtaken by developments since the review was carried out"* (CPS100312, p1).

9.121 On 8 September, Nina Lakhani reported the findings of the Baker Report in the *Independent on Sunday*, suggesting that the Government would grant an independent inquiry. Under the headline *"Gosport hospital deaths to get public inquiry at last; Ten years after a 'death audit' was triggered by claims of opiate overuse, ministers are set to act"*, the article stated:

> "An independent inquiry into the deaths of dozens of elderly patients given 'life-shortening' powerful painkillers at a Hampshire hospital will be announced by ministers within weeks.
>
> The inquiry will address the findings of a damning audit into deaths at Gosport War Memorial Hospital published last month, a senior government figure told The Independent on Sunday.
>
> The audit by Professor Richard Baker, a patient safety expert from the University of Leicester who also worked on the Harold Shipman inquiry, found morphine and other powerful sedatives were routinely prescribed to elderly patients in Gosport between 1988 and 2000, even if they were not in pain.
>
> A 'remarkably high' proportion of patients were given opiate injections before death, the Baker report states. The 'routine' use of these powerful drugs 'almost certainly shortened the lives of some patients', some of whom might have survived their illness and been 'discharged from hospital alive'.
>
> Professor Baker's recommendations included investigations into individual deaths, and a study of shift patterns to ascertain whether deaths were linked to particular nurses and doctors.
>
> Serious concerns about the liberal use of opiates among elderly patients at Gosport were first reported by nurses in 1991, but continued for another decade. Complaints from families in 1998 eventually led to three police investigations, 11 belated inquests and a professional misconduct hearing.
>
> The Baker report was suppressed by the Department of Health for almost 10 years on the grounds that it could interfere with these proceedings. The report has reignited families' calls for an independent inquiry into the deaths and subsequent 'flawed' investigations which were mired by delays.

> The senior source said an inquiry should also examine confidential documents held by the police, Crown Prosecution Service, NHS and government departments, so relatives' outstanding questions and cover-up allegations could be addressed." (OSM100958, p1)

Conclusion: what is added to public understanding

- The Panel has seen no documents suggesting that the concerns expressed by the nurses in 1991 were drawn to the attention of either the local or national media at the time.
- The documents available to the Panel show that the first time the local or national media covered the relevant allegations was in April 2001, over two and a half years after Gillian Mackenzie contacted Hampshire Constabulary, thereby bringing about the police investigation.
- The documents show the prominent part played by the *Portsmouth News* in pursuing concerns about Gosport War Memorial Hospital ('the hospital') and the related police investigations, as well as the accuracy of its early reporting.
- The documents illustrate the sometimes close relationship between the police and the media.
- On 3 April 2001, the *Portsmouth News* published the story on its front page under the headline *"Probe Into Suspicious Death at Hospital – police investigation into alleged unlawful killing of patient, 91"*. The article suggested that detectives had prepared a dossier on the death and that the police might have to re-examine up to 600 other deaths at the hospital. The article put into the public domain the main issues at the hospital, which have taken a further 17 years to come fully to light.
- The documents show how the police and the healthcare organisations made contact when the media raised questions.
- The local media made a connection between the response to the criticisms being made by the relatives of the patients and the pride felt about the hospital in Gosport.
- The documents illustrate that the media coverage played a significant part in encouraging staff who had worked on the wards to take action.
- Local media coverage reflected a number of the concerns of the Gosport families. National media coverage also did so. The latter was episodic and was informed, for example, by the interest shown by the medical correspondent of *The Sunday Times*, Lois Rogers, and by the health reporter of the *Independent*, Nina Lakhani.
- Local and national media coverage of the hospital intensified in the course of 2009 as the inquests began and the General Medical Council pursued the question of Dr Jane Barton's fitness to practise. Media comment became more critical of the hospital and the investigative processes and more in tune with the dissatisfaction expressed by bereaved relatives of patients at the hospital. This would prove to be a transition towards a period of growing demand for some form of independent inquiry.

Chapter 10: The local MP

Introduction

10.1 Chapters 4 to 9 show what the documents say about the response of the relevant authorities to the concerns expressed by families. This chapter completes that process, by looking at how the documents highlight the response of the Member of Parliament. Sir Peter Viggers was the MP for Gosport from 1974 to 2010 and, as such, was the local MP for Gosport War Memorial Hospital ('the hospital'). Indeed, Sir Peter was born in Gosport and his connections with the area are long standing.

10.2 Sir Peter served in the Royal Canadian Air Force and the Royal Wessex Regiment. Since 1972 he has been chairman and director of various public and private companies and an underwriter at Lloyd's. He served as Parliamentary Under-Secretary of State (Industry Minister) in the Northern Ireland Office from 1986 to 1989 and was knighted for his services to Parliament in 2008.

10.3 This chapter covers the documents seen by the Panel describing Sir Peter's approach to concerns raised about the hospital. Reflecting the timing of his knighthood, Sir Peter is described as Mr Viggers in this chapter before 2008. Caroline Dinenage was elected as the local MP in 2010, and the chapter also includes reference to her involvement.

Initial involvement

10.4 When the hospital faced closure, Mr Viggers was part of the campaign to keep it open, as he would later make clear in the House of Commons (FAM004456, p2).

10.5 The first reference in the documents reviewed by the Panel is a letter from Mr Viggers to Gillian Mackenzie, the daughter of Gladys Richards, on 26 February 2001. His letter refers back to papers provided by Mrs Mackenzie to Councillor Bartlett suggesting a meeting between Councillor Bartlett and himself. Mr Viggers said that he would need to have details of the problem before he could decide whether there was any action he could properly take (FAM004408).

10.6 Within three days of his first letter, Mr Viggers wrote to Mrs Mackenzie again. He referred to Mrs Mackenzie having spoken to his secretary on the telephone. Mr Viggers' letter points out that, since Mrs Mackenzie did not live in the constituency of Gosport, in line with the convention, he could not take up her case. He would transfer it to Nigel Waterson, her constituency MP, if she wanted him to do so (FAM004409).

10.7 In a letter of 7 March, Mrs Mackenzie explained why she had written to Mr Viggers and had no intention of involving Mr Waterson. She explained that the issue as to whether Mrs Richards had been unlawfully killed was now with the Crown Prosecution Service. The hospital was in Mr Viggers' constituency and it was in the interests of his constituents that he should be

aware of the situation. Mrs Mackenzie offered to meet with Mr Viggers and pointed out that her sister, Lesley Lack, did live in his constituency (FAM000982). Mr Viggers' office acknowledged Mrs Mackenzie's letter on 12 March: he was away and would see the correspondence the following week on his return.

10.8 On 3 April, the *Portsmouth News* reported the police investigation into the alleged unlawful killing of a 91-year-old woman and referred to her daughter, Mrs Mackenzie. A related article recalled that the town had fought for its hospital: *"the people of Gosport are proud of the complex – and defensive of it"* (DOH603574, p1).

10.9 The following day, the *Portsmouth News* reported that the Department of Health and its Ministers were aware of the police investigation. Under the headline *"MP passes papers on to colleague"*, Mrs Mackenzie was reported as having given a file to Mr Viggers, who in turn had passed it on to Mr Waterson. Mr Viggers was said to have stated that he was satisfied that the case was being properly handled by the Hampshire Constabulary and by the Portsmouth HealthCare NHS Trust, adding: *"I would only become involved if there was a breakdown of the normal authorities"* (DOH603590, p1).

10.10 On 17 April, Mr Viggers wrote to Max Millett, Chief Executive of Portsmouth HealthCare NHS Trust, referring to Mrs Mackenzie's approach to him and to the press reports. He asked for a briefing from the appropriate person (DOH600057, p3).

10.11 Mr Millett replied two days later, confirming that Mrs Richards' case was being considered by the Crown Prosecution Service. Mr Millett added that there had been a second complaint from a relative about the care of another patient at the hospital, also in 1998. Mr Millett said that this complaint had been investigated internally. The relative had remained unhappy and referred his complaint to the Health Service Ombudsman who had not found evidence of unsatisfactory medical or nursing care. Mr Millett said that the Ombudsman was satisfied that the patient was not given excessive doses of morphine. He did not uphold the complaint (DOH600057, pp1–2).

10.12 Mr Millett's letter stressed that the Ombudsman's investigation was independent of the Trust and involved external medical and nursing advisers. Mr Millett pointed out: *"the only criticism of the Trust made by the Ombudsman was for an error relating to the microfilming of some nursing records, e.g. fluid charts, but the majority of the patient's records were available and were adequate for the advisers to assess the adequacy of care."* The relative was unhappy with the Ombudsman's findings and had asked the police to investigate his complaint as another unlawful killing (DOH600057, pp1–2).

10.13 Mr Millett went on to draw attention to the fact that the *Portsmouth News'* coverage had also referred to three or four more people having approached them with similar concerns. He said that the Trust had received no formal complaints from these 'new' names, and had not previously been aware of their concerns. He made it clear that the Trust was *"more than ready to meet with anyone who has concerns about the care of their relative in this hospital".* None of the people mentioned, Mr Millett suggested, had contacted the Trust, either directly or via the *Portsmouth News*. Mr Millett said that there were therefore only two definite complaints to date. One had been fully investigated by the police, and the other had been subject to an independent investigation which had concluded that the care given was appropriate (DOH600057, p2).

10.14 Mr Millett concluded his letter by saying that he hoped this had given Mr Viggers sufficient background on the situation but that he should not hesitate to contact him again if he could help further (DOH600057, p2).

10.15 On 23 October, the *Portsmouth News* reported that the Commission for Health Improvement (CHI) would be investigating. Mr Viggers was quoted as saying: *"In the many years I have been a Member of Parliament for Gosport, I have had nothing but praise for Gosport War Memorial Hospital"* (DOH603421, p1).

Further involvement

10.16 On 25 January 2002, the *Independent* reported: *"Woman says Tory MPs refused to help her in medical dispute."* The newspaper reported Mrs Mackenzie as saying that she had tried to enlist the support of Mr Viggers but that:

> "Westminster convention prevented him becoming involved … They had just been dismissive, totally dismissive. They should at least take a look at the papers. While I appreciate that Nigel Waterson is in a difficult position, Mr Viggers should take an interest in matters involving his own constituency." (FAM600315, p1)

10.17 Mr Viggers is quoted in the same article: *"I have never had any complaint about Gosport War Memorial Hospital. The doctors are very dedicated"* (FAM600315, p1).

10.18 On 15 April, Mr Viggers wrote to Marilyn Jackson thanking her for sending him her letters to the police and the General Medical Council about the death of her mother, Alice Wilkie. He told Mrs Jackson that, in the first instance, he had asked the Chief Constable for a copy of his response (FAM003144).

10.19 On 18 May, Iain Wilson wrote to Mr Viggers enclosing a copy of his complaint about the police investigation into the circumstances of the death of his father, Robert Wilson. In his letter, Iain Wilson said:

> "I live in your constituency my father was unlawfully killed in it, I believe that you are duty bound to not only raise questions in the House with regards the standard of care and the increase in deaths at the War Memorial, but to also put pressure and lobby the Home Secretary to reopen this investigation. This is what we now expect you to do, anything less will just not be acceptable." (IMI000356, p1)

10.20 Three days later, Mr Viggers replied. He said that he had recently met the Chairman and Chief Executive of the Primary Care Trust (PCT) and had a further meeting with them arranged shortly. He pointed out that the CHI report was awaited and said that he was also in touch with the police. He concluded his letter by saying: *"This is a most sensitive issue and I should like to express my sympathy to those who have been bereaved. I will write to you further in due course"* (IMI000360, p1).

10.21 On 8 July, Ann Reeves wrote to Mr Viggers complaining about his lack of action and saying that he had ignored her previous letters. On 16 July, Mr Viggers replied saying he was aware of the distress of families whose relatives had died in the hospital. He added: *"Nevertheless, having kept in touch with the hospital over the years and, of course, read the CHI report, I believe we should respect the commitment and dedication of those who work at the hospital and provide a high standard of care"* (FAM003143, p1).

10.22 In the course of the same month, Mr Viggers received further letters from family members. On 15 July, Marjorie Bulbeck questioned whether he had read and absorbed the implications of the CHI report, given that he had commented 24 hours after its publication. She added: *"You should be reassuring your constituents that NOW it is a safe hospital only because people like*

myself have had the courage to complain, if we had not patients would still be enduring the regime and dying" (FAM001314, p1).

10.23 Mr Viggers replied on 22 July. Having read the CHI report and discussed it with the Fareham and Gosport PCT, he did not think that her comments were justified. In his typed letter, Mr Viggers said: *"Some very extravagant language has been used by a small number of people, but this does not alter the fact that a high standard of care is provided by a devoted staff."* In a handwritten note Mr Viggers added: *"Having said that, I am of course sorry that you were dissatisfied with your mother's treatment"* (FAM001312, p1).

10.24 In between receiving Mrs Bulbeck's letter and replying, Emily Yeats wrote to Mr Viggers on 17 July 2002 about the hospital and her grandmother's death. Responding to his comments in the *Portsmouth News* on 5 July, she said that it was shameful that, after all this time, he still did not appear willing to accept that there were serious problems at the hospital relating to drugs given and the standard of care received (FAM003140, p1).

10.25 Miss Yeats added:

> "You appear happy to back a hospital which appears willing to protect wicked individuals who took it upon themselves to administer these drugs to people. I think that your comment referring to the pressures placed on staff at the hospital as a result of complaints is misguided to say the least. I'll tell you something now - if it had not been for families' complaints and continuing to fight despite being knocked back time and again the CHI report would never have been written, procedures not changed and I fear people would still be dying unnecessarily. BUT, the report does exist and you cannot ignore its presence or its damning contents." (FAM003140, p1)

10.26 Miss Yeats concluded her letter:

> "If you had any heart or sense of conscience you would be calling for the individuals responsible for this tragedy to be held accountable for their actions. After all, the Fareham and Gosport Primary Care Trust (PCT) may be attempting to hide behind a systems failure excuse, but it is clear to anybody that actually looks at these cases, that whilst the trust IS at fault for failing to put systems in place to prevent an individual from allegedly committing a criminal act, the fact remains that an individual doctor 'chose' to administer those drugs which CHI has acknowledged were excessive and inappropriate. This from a doctor with many years of training and experience. Its time you stood up for what is right Mr Viggers and push for justice. Stop pretending that these problems don't exist. After all, its there for you in black and white." (FAM003140, pp1–2)

10.27 A month later Mr Viggers responded to Miss Yeats, confirming that his comments about the hospital had been correctly reported, adding:

> "Medical practice has changed in recent years and it is no longer possible for doctors to prescribe a range of medicines, leaving a level of discretion to nurses. Personally, I regret the litigious spirit which has caused doctors to become more defensive. For the record, I disagree with a number of statements you make in your letter and the manner in which you express these." (FAM003141, p1)

10.28 Three months later, on 20 November 2002, the *Portsmouth News* reported that Mr Viggers had visited the hospital to meet patients and staff and show his support. Mr Viggers is quoted as saying: *"In light of the bad publicity the hospital has been receiving, I wanted to walk through*

the hospital to say 'hello' to patients and staff and to wish them well … The patients were more than happy to tell me about the high standard of care they were receiving." Mr Viggers is then quoted as adding: *"One relative rushed after me along the corridor to praise the work that they did. They are doing a great job"* (FAM000050, p47).

Debate in the House of Commons

10.29 Mr Viggers spoke in a debate in the House of Commons, known as a Pre-Recess Adjournment Debate, on 19 December 2002. The motion for the debate was *"That this House, at its rising on Thursday 19th December, do adjourn until Tuesday 7th January".* These debates enable MPs to raise issues of concern to them individually and locally, and there is no single or unifying theme (FAM004456).

10.30 The debate began at 1.16pm and Ben Bradshaw MP, Parliamentary Secretary in the Privy Council Office, responded for the Government at 6.45pm. Mr Viggers spoke at 2.27pm and concluded his remarks at 2.41pm. The theme of his contribution was the NHS and how it was deteriorating. He identified five local illustrations relevant to his constituents. The first was podiatry, chiropody and general foot care. The second was dentistry. The fourth was Queen Alexandra Hospital, which he said was in crisis. The fifth was the Royal Hospital Haslar (FAM004456).

10.31 Mr Viggers' third illustration concerned Gosport War Memorial Hospital, which he described in the following terms:

> "There was a campaign to close it, but I was part of a campaign to keep it open and it became a community hospital. It is very highly regarded, conveniently located in Gosport and has caring staff, and its league of friends — as active as any in the country — is very successful at raising money for what is a much appreciated and loved hospital for which people used to have nothing but praise.
>
> In the long period during which I have represented Gosport, I never received any complaints about Gosport War Memorial hospital until a woman who lives in Eastbourne complained about the death in the hospital of her mother, who was in her 90s. Deeply though one regrets that lady's death, the complaint was that she had been put on diamorphine. In those days — we are talking about 1998 — prescription practice was rather less specific than it is now. It was not unusual for a doctor to prescribe a range of diamorphine levels and leave decisions about how much a patient needed to the discretion of nurses.
>
> That practice is what I would expect in a hospital where doctors and nurses know and trust each other. However, that did not satisfy the woman, who complained bitterly and demanded a police inquiry into the alleged illegal killing of her mother. The police conducted an inquiry and concluded that there was nothing further to inquire into. The woman made a further complaint, and a second police inquiry reached the same conclusion as the first.
>
> Further agitation, and by that time the keen interest of local newspapers, led the PCT and others to decide that it would be appropriate to hold a further inquiry so as to reassure all the people dealing with the hospital. The Commission for Health Improvement carried out that inquiry and produced an action plan that is now being followed. That brought the total number of inquiries to three.

> However, the complainant kept going. By then, other people had begun to wonder whether they might have something to complain about after their 80 and 90-year old relatives had died in the hospital. Eventually, Sir Liam Donaldson, the chief medical officer, appointed Professor Baker to carry out a clinical audit of the hospital. That made four inquiries. However, the press was by then building up interest, and 57 people complained that their relatives might have died because of inappropriate treatment. Another police inquiry — the fifth inquiry overall — has been launched, and a firm of solicitors that took part in the Harold Shipman case has also become involved, possibly helpfully, although the name Shipman means that newspaper reporters have become even more excited.
>
> The strategic health authority decided that there should be a further inquiry into the hospital's management over the past 10 years, and the chairmen of the two PCTs concurred. That makes six inquiries. Meanwhile, the General Medical Council is carrying out a seventh inquiry, and the Nursing and Midwifery Council an eighth.
>
> The House can imagine the cost, and the effect on management, of all those inquiries. I only hope that they all conclude quickly. I have visited the hospital twice recently to meet patients and staff and to say that I know the hospital to be highly regarded. I want to thank again all the staff and everyone involved in the hospital for what they have done to maintain a high standard of care in the Gosport area. I hope that the matter is resolved soon." (FAM004456, p2)

10.32 Mr Viggers concluded his speech by saying:

> "These examples show that the Government are wrong. Thinking that they know best and that services can be centralised and controlled leads not to improvements but to deterioration. I hope that the Secretary of State for Health will read the report of this debate and respond to the points that I have raised, because there are serious concerns about the national health service in my area." (FAM004456, p3)

10.33 In winding up the debate, Mr Bradshaw responded to Mr Viggers' remarks about the Royal Hospital Haslar but not to his reference to Gosport War Memorial Hospital.

Involvement after the House of Commons debate

10.34 On 3 January 2003, the *Portsmouth News* reported that a 'row' had erupted after Mr Viggers had criticised the cost and time being spent on an inquiry into deaths at the hospital. The article reported him as saying that the ongoing investigations had dragged on since Mrs Mackenzie had complained:

> "The Commission for Health Improvement (CHI) Report cost, I believe, £100,000 and there have been several Police reports that Mrs Mackenzie has found unsatisfactory. What I am pleading for a is a measure of finality in this; recognition that at the end of the day we need facts exposed and opinions expressed, then we need to move on. Eight inquiries into one hospital is a very large number of expensive and time consuming investigations." (FAM000050, p58)

10.35 In the same article, Mrs Mackenzie was quoted as saying:

> "Mr Viggers should be doing more research before making comments like this. The police called in the GMC and they backed the case going to the Crown Prosecution

Service. He has never had the courtesy to reply to my letters or to those of others who have written to him." (FAM000050, p58)

10.36 A note prepared by the Communications Manager of Hampshire and Isle of Wight Strategic Health Authority drew the attention of the Department of Health, CHI and the Hampshire Constabulary to the article and stated: *"At the time, I commented that the MPs statement might not be viewed as sympathetic to the families and to the need to investigate these matters fully"* (DOH000393, p2).

10.37 On 11 February, BBC Radio 4 broadcast a programme in its *File on 4* series which examined the allegation that the lives of elderly patients were being shortened by their treatment. The programme included Mr Viggers' interview with the BBC's reporter, David Lomax:

"LOMAX: Last week, in a hotel in nearby Fareham, more than a hundred people, including bereaved relatives, attended a private meeting about the Gosport case. File on 4 has been told that the police reassured relatives that they were taken their investigations seriously and that these were continuing. The local MP, Peter Viggers, told the House of Commons recently that it was now time to draw a line under all these inquiries. There had so far been eight of them, he said, and the House could imagine their cost and the effect on the management of what he called a much loved and appreciated hospital. If it is so good, why is it that there have been so many allegations about how elderly patients are being treated here?

VIGGERS: There has been a massive amount of local publicity, particularly in the local newspaper, and more and more people, having read the local newspaper, I think have come to the conclusion that perhaps as they have a relative or a friend who died here, perhaps something could have been done to help him or her more than was done.

LOMAX: But you're not suggesting these allegations are made without sincerity?

VIGGERS: It's not for me to probe motives. I have no doubt at all, from considerable correspondence that I've had, that people are distressed about the loss of their dear ones here. Some of the allegations which are being made are perhaps a bit extreme.

LOMAX: But the fact is that in the CHI investigation here, there were serious concerns discovered.

VIGGERS: Well, no doubt CHI feel a sense of satisfaction at having found something to put in their report.

LOMAX: But isn't it true that if it had not been for people making these allegations, there would not have been a series of inquiries, and they wouldn't have discovered the practices that were on a couple of wards here taking place?

VIGGERS: I don't want to comment on that.

LOMAX: But it's true.

VIGGERS: I don't want to comment on it.

LOMAX: But these were your constituents who are making these complaints.

VIGGERS: I really do not want to comment on the CHI report." (FAM001167, pp11–12)

10.38 There are no documents available to the Panel which show any further comment from Mr Viggers, either directly to the points made by the *Portsmouth News* about his remarks or to the *File on 4* broadcast. The documents do show that Mr Viggers' continuing concern was the number and length of the inquiries and their effect on the staff at the hospital.

10.39 Mr Viggers expressed his concern once again in a letter to John Reid MP, then Secretary of State at the Department of Health, on 13 February 2004:

> "The Department of Health recently announced that it was aiming to ensure that all medical enquiries should be completed within two months. Following allegations by a woman about the death of her mother at the Gosport War Memorial Hospital, there have been various enquiries which have expanded with the passage of time. The Hospital faces continuing enquiries which are inevitably having a serious effect on morale. May I please ask how your new proposal to limit the term of enquiries can be reconciled with the situation at Gosport War Memorial Hospital, and when may we expect to have a conclusion of this matter?" (DOH700013, p4)

10.40 In replying to Mr Viggers, Rosie Winterton MP, as the Minister responsible for health services in the south of England, clarified that the Department of Health announcement concerned only the timetable for the Commission for Healthcare Audit and Inspection in investigating complaints. Her letter continued:

> "Turning to the concerns you have raised about the investigations into deaths at Gosport War Memorial Hospital. As you are aware, there is a ongoing police inquiry into the past care and treatment of patients at the Hospital and it is not appropriate for me to comment on this. However, I am assured that the NHS in Hampshire and the Isle of White has co-operated fully with Hampshire Constabulary during the investigation and will continue to do so. I also understand that the Hampshire police are keeping the families fully informed of how their investigation is going at every stage. I hope this addresses the points you have raised." (DOH700013, pp2–3)

10.41 Mr Viggers wrote to Lucy Docherty, Chair of Fareham and Gosport PCT, on 30 March 2004 and enclosed his correspondence with the Minister (DOH700013, p1).

10.42 On 13 September 2004, Mr Viggers asked the first of three Parliamentary Questions relating to the hospital. On this occasion his question to the Home Secretary was in two parts. First, when did the Home Secretary expect inquiries into medical and nursing practices at Gosport War Memorial Hospital to be concluded. Second, how many man-hours had been expended by staff at Gosport War Memorial Hospital in responding to inquiries about medical and nursing practices at the hospital.[1]

Subsequent involvement: 2007 to 2010

10.43 In the second Written Parliamentary Question to the Home Secretary on 5 February 2007, Mr Viggers asked how many police man-hours were involved in the most recent Hampshire Constabulary investigation into alleged unlawful killings at the hospital, and at what cost.[2]

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1 House of Commons Debate, 13 September 2004. Hansard, vol 424, cols 1404–5W. http://hansard.millbanksystems.com/written_answers/2004/sep/13/gosport-war-memorial-hospital#S6CV0424P2_20040913_CWA_79 (accessed 17 April 2018).

2 Written Parliamentary Question, 5 February 2007. Daily Hansard, col 156W. https://publications.parliament.uk/pa/cm200607/cmhansrd/cm070205/text/70205w0017.htm#07020558001032 (accessed 17 April 2018).

10.44 The next documents available to the Panel concern Mr Viggers' correspondence with Charles Stewart-Farthing, the stepson of Arthur Cunningham. Mr Viggers wrote to Mr Stewart-Farthing on 13 June 2007 reporting that he had pursued the issue raised with him relating to his stepfather's death and enclosing a letter from the Chief Constable dated 29 May. Mr Viggers noted that Mr Stewart-Farthing had met with the Senior Investigating Officer (FAM001910, p1). On 27 June, Mr Viggers wrote again, acknowledging that Mr Stewart-Farthing had provided him with a copy of a letter to the Chief Constable (FAM001909).

10.45 Mr Viggers was knighted for his services to Parliament in 2008. In March 2009, he commented publicly on the eve of the inquests into the deaths of ten patients. On 17 March, BBC News reported Sir Peter as saying: *"There have been so many inquiries, there was a police inquiry that came to a conclusion that no further action was required. I like and know the hospital and the people there and would like the issue to be allowed to rest"* (MRE001217, p2).

10.46 Two days later, the *Portsmouth News* published an editorial which included this statement of why it disagreed with Sir Peter's view:

> "We certainly believe a formal inquiry into the circumstances surrounding the deaths of their loved ones can help them to feel some comfort and reassurance that every detail has been examined. So we do not agree with Gosport MP Sir Peter Viggers, who has criticised the decision to hold a coroner's inquiry. His argument is that the police have already looked into the deaths and decided that no action was required. In his mind, it's better to let the matter rest. He is factually right in that the deaths have been the subject of three inquiries by Hampshire Police and a probe by the Crown Prosecution Service. But, with respect to Mr Viggers, he is not one of those who has lost a much-loved relative. He can't know how much it means to them. Also, some would say that previous investigations have not exactly been conclusive and that an exhaustive inquiry should have been held before now. We believe re-opening the inquests is the right way to proceed. It may take time, but we hope they give relatives the information they feel they are still missing after all these years." (FAM000614, p1)

10.47 Families affected also made it clear that they rejected Sir Peter's position. Gail Bragginton wrote to him expressing her disgust:

> "Our mother was one of those singled out to be prematurely terminated and this was three years before the whole situation became public. No matter that eight previous inquiries were inconclusive, we who were involved knew what was going on: in the last week of my mother's life my sister said to one of the doctors, 'So, you are going to pump our mother full of morphine until her body cannot take any more'. His reply was, 'That's your opinion'. Any regime that allows pre-signed prescriptions for diamorphine which is then administered by nurses when they see fit is inherently unsafe, at the very least. It is already clear that in some cases this drug was administered to patients who had no clinical reason to receive it intravenously via a driver 24/7." (FAM002715, p1)

10.48 Mrs Bragginton challenged Sir Peter:

> "If your mother had been terminated in the same way as ours, you, too, would want to know who was responsible even if their actions fall short of murder or manslaughter. In the meantime, your remarks are extremely hurtful and offensive to those of us who have lost our relatives and want to know the truth about their deaths. Why do you think that after 13 years families are continuing this fight? Clearly there is some case to answer." (FAM002715, p1)

10.49 Sir Peter sent the following short letter in reply: *"Thank you for your letter of 23 March. I note the points you make and I am sorry that my remarks distressed you"* (FAM002716, p1).

10.50 In the third of his Written Parliamentary Questions about the hospital, Sir Peter asked the Secretary of State for Health to publish the report prepared by Professor Richard Baker.[3]

10.51 The Panel is aware that Sir Peter was interviewed by the BBC about his position on inquiries into what happened at the hospital. The interview was not broadcast.

10.52 On 23 April 2009, the *Portsmouth News* reported the outcome of the inquests and the families' reaction in a number of articles. One of them, headed *"Relatives call for a public apology from MP in wake of hearings"*, quoted Mr Stewart-Farthing: *"He has got several apologies to make. His behaviour has been unforgivable from the beginning."* The article also quoted Mrs Mackenzie: *"I want him to apologise to me in the House of Commons"* (FAM002247, p1).

10.53 In the same article, Sir Peter is said to have refused to talk to the newspaper but to have given the following statement: *"I have always supported the work of the [Gosport] War Memorial Hospital which has an important place in the local community. Similarly, I have supported the work of the medical, nursing and auxiliary staff. I do not propose to make any comment on the inquest until I have had the opportunity to read the report in full"* (FAM002247, p1).

10.54 At the General Election in May 2010, Caroline Dinenage was elected as MP for Gosport. On 7 September 2010, the front page of the *Portsmouth News* reported that the *"MP backs calls for hospital deaths inquiry"*. Caroline Dinenage was said to want an official probe to find out what happened at the hospital. Iain Wilson, a bereaved family member, was reported as saying: *"We used to have an MP who said he wouldn't help and now we've got an MP saying she will help in any way she can. I think having the constituency MP on board could really change things. It's given me new hope"* (FAM002294, p2).

Conclusion: what is added to public understanding

- **Sir Peter Viggers, as the local MP, was consistent in his defence of Gosport War Memorial Hospital, having told the House of Commons that he was part of a campaign to keep it open.**
- **Sir Peter was also consistent in not supporting his constituents in pressing for further investigations. His questions in Parliament concerned when existing investigations would be published, and their cost, rather than raising concerns expressed by his constituents.**
- **At the General Election in May 2010, Caroline Dinenage was elected as MP for Gosport. On 7 September 2010, the front page of the *Portsmouth News* reported: *"MP backs calls for hospital deaths inquiry"*. Caroline Dinenage was said to want an official probe to find out what happened at the hospital. Iain Wilson, a bereaved family member, was reported as saying: *"We used to have an MP who said he wouldn't help and now we've got an MP saying she will help in any way she can. I think having the constituency MP on board could really change things. It's given me new hope."***

3 Written Parliamentary Question, 23 March 2009. Daily Hansard, col 156W. https://publications.parliament.uk/pa/cm200809/cmhansrd/cm090323/text/90323w0034.htm#0903241000701 (accessed 17 April 2018).

Part III

The work of the Gosport Independent Panel

Chapter 11: The Panel's work

Introduction

11.1 Chapters 1 to 10 of this Report provide an overview of the information reviewed by the Panel and illustrate how the information disclosed adds to public understanding of the deaths and treatment of patients at Gosport War Memorial Hospital ('the hospital'). Chapter 12 sets out a summary of the Report and its conclusions.

11.2 This chapter explains more about the work of the Gosport Independent Panel. The Panel was established in order to fulfil the Terms of Reference in Appendix 1. The Terms of Reference refer to concerns about the care of older patients at the hospital, which have been the subject of scrutiny since 1998, and to the unanswered questions that have remained for the families about the care of their relatives. This chapter explains how the Panel has worked to deliver its Terms of Reference and to answer the families' questions.

11.3 This chapter lists the members of the Panel and describes its principles and how it has carried out its work.

Panel membership

11.4 The Gosport Independent Panel has been chaired by The Right Reverend Bishop James Jones KBE, with the following members:

- Kate Blackwell QC
- Christine Gifford
- David Hencke
- Duncan Jarrett OBE
- Dr Bill Kirkup CBE
- Dr John Pounsford
- Professor Jim Smith
- Professor Deborah Sturdy OBE

Information about the Panel members is available on the Panel's website.

11.5 The Panel has been supported by a Secretariat led by Louise Dominian.

Principles

11.6 While entirely independent in terms of scope and delivery of its Terms of Reference, the Gosport Independent Panel was funded by the Department of Health, called the Department of Health and Social Care from January 2018, as the sponsor department. The fundamental

principle of independence was key to the work of the Panel and was adhered to throughout its work. As a contributing organisation, the Department of Health and Social Care was treated in exactly the same way as all other contributors. Further comment about the relationship between the Panel and the department is made later in this chapter.

11.7 The Terms of Reference required the Panel to:

- oversee the maximum possible public disclosure of all relevant information relating to unexpected deaths and treatment at Gosport War Memorial Hospital
- manage the process of public disclosure, initially to the affected families
- produce a report which will provide an overview of the information reviewed by the Panel and illustrate how the information disclosed adds to public understanding of these events and their aftermath
- establish an online archive of Gosport documentation, including a catalogue of all relevant information and a commentary on any information withheld for the benefit of the families or on legal or other grounds.

11.8 The principle of 'families first', enshrined by the commitment to disclose initially to the affected families, has been fundamental to the Panel's work.

How the Panel has carried out its work

11.9 The Parliamentary Under-Secretary of State at the Department of Health, Norman Lamb MP, announced the Panel's Terms of Reference in a Written Parliamentary Statement on 9 December 2014. The Panel met for the first time on 13 January 2015 and on a monthly basis thereafter. In between Panel meetings, respective Panel members, working with members of the Secretariat, led work on accessing relevant documentation and on research reflecting their specialist skills and experience.

Engagement with the families and family material

11.10 The families of those affected by events at the hospital were central to the work of the Panel. Initially, the Panel held two meetings with a small number of families in Gosport between July 2014 and December 2014, when the Terms of Reference were formally announced. These meetings were used to begin to understand the concerns of the affected families and the questions that would help to shape the Panel's Terms of Reference.

11.11 In the summer of 2015, the Panel undertook a series of activities to raise awareness of its work in the local community. This included but was not limited to: adverts in the local press, TV and radio interviews, and a press release. This activity saw a significant increase in the number of families that came forward to engage with the Panel.

11.12 An exercise to trace those families whose relatives had been included in previous police investigations but who were not already in contact with the Panel was conducted in the summer of 2016. This again saw an increase in the number of families coming forward with concerns about events at the hospital.

11.13 The approach to family engagement included both formal meetings between Panel members and families, and a flexible, personal approach led by the Secretariat's Family Team. Since 2014, the Panel has established contact with families relating to 145 patients. The Panel asked the families if they had any questions or concerns relating to the care and treatment

of patients at the hospital during the period covered by the work of the Panel. There were over 750 questions and concerns from families, and these provided a basis for the thematic approach adopted by the Panel.

11.14 A number of families attended family liaison meetings, which were held four times a year, the first taking place on 9 December 2014 and a further 12 occurring before disclosure of the Report. The meetings were used to keep families up to date with the progress of the Panel, while ensuring that there was no breach of the principle of 'no piecemeal disclosure', and were also intended to provide an environment where families could meet to talk and share their experiences. The Panel asked the families to provide any documentation they had to the Panel so that it could be analysed as part of the thematic approach. In response, the families provided a total of 12,512 documents to the Panel. All families, including those who were unable to attend the family liaison meetings, were sent notes of these meetings to ensure that they were kept informed of the progress of the Panel's work. The agendas for these meetings and the relevant Notes for Families are available on the Gosport Independent Panel website (https://gosportpanel.independent.gov.uk/meetings).

Stakeholder identification

11.15 In order to identify those organisations and individuals likely to hold relevant documents, a process was carried out using the expertise and knowledge of the Panel and recommendations from others. A table of contributing organisations and individuals is included at the end of this chapter.

11.16 Given the passage of time, some organisations had disbanded or merged, but where this was the case successor and legacy organisations were identified and contacted regarding any material they might hold. Not all those who were contacted held material that was relevant to the Panel's work.

11.17 Some stakeholders could not at first locate information relevant to the work of the Panel. However, where the Panel had reason to believe that such information had existed at some point in time, the stakeholder was asked to search again and this often generated positive results.

11.18 A list of those who were contacted but did not provide any material to the Panel is also attached in a table at the end of this chapter (Table 6). Some said that they had never held any relevant material, others that relevant documentation had been destroyed because of the lapse of time, while others were unable to locate it. Some provided information through third parties such as the Department of Health because of their employment status at the relevant time.

Stakeholder engagement and collection of material

11.19 As soon as stakeholders were identified, they were asked not to destroy any material that might be relevant. This was quickly followed by the development of an Access and Disclosure Protocol. Introductory meetings were held with key stakeholders to explain the Panel's work and to request that extensive searches be carried out for relevant material.

11.20 The Panel worked with stakeholders through a two-phase process:

- During phase one, the Panel asked stakeholders to search for relevant material and to provide it, in confidence, to the Panel. Without exception, all information relevant to our work that stakeholders acknowledged they had was provided to the Panel.

- In phase two, the Panel asked stakeholders to identify what, if any, information they felt unable to disclose into the public domain using narrow criteria established in the Access and Disclosure Protocol and a separate Redaction Framework. Both these documents can be found on the Panel website.

11.21 Engagement with all stakeholders continued throughout the work of the Panel, as further questions were raised during the process of reviewing the material, including revisiting organisations or individual stakeholders who were initially unable to provide the Panel with any documentation.

11.22 The Panel collected a total of 141,491 documents, not all of which have been disclosed in the online archive. Documents withheld from disclosure include medical records, death certificates, sensitive personal family material and documents that were identified as either out of scope or not relevant to the Panel's work.

11.23 Out of the total of 141,491 documents supplied to the Panel, it was found that:

- 75,444 were out of scope
- 19,513 were of a sensitive nature or relevant specifically to individual families, such that it was felt not to be in the public interest or in keeping with the law relating to data protection to put these in the public domain.

This third category of documents will, however, be made available to individual families on a personal basis should they so wish. Where documents add to public understanding of events at the hospital, extracts have been included in the Panel's Report with the consent of the families concerned.

Processing of information

11.24 The Panel complied with the requirements of the Data Protection Act 1998 by registering with the Information Commissioner's Office as a data controller. In order to meet and maintain the standards required, the Panel designed and implemented a set of processes and protocols to manage the documentation provided by stakeholders including families.

11.25 Material was received in a wide range of formats: paper documents, letters and reports, newspaper articles, emails, electronic documents, paper records, microfiche and audio cassettes. The variety of formats of material received is a reflection of the rate of change in technology during the period of time being reviewed by the Panel. To facilitate management and analysis, all paper documentation was catalogued and scanned onto a document management system known as Relativity, provided by DTI Global, now Epiq. Information already in electronic format was loaded onto the same system. This enabled the research process to be carried out electronically in a secure state and for documents to be accessed simultaneously by multiple members of the research team.

11.26 A note on references. The referencing system used to link documents mentioned in the text to their source material indicates the initial source from which the Panel obtained the source material (for example, HCO for Hampshire Constabulary or CPS for the Crown Prosecution Service). In many cases, this only reflects the repository for the documents, and should not be taken as an indication that the organisation knew of the document or its contents from the date of origin. This applies particularly to documents referenced with a DOH prefix: the Department of Health was the legacy organisation to which documents passed after a range of NHS bodies were reorganised or abolished, including Health Authorities, Strategic Health Authorities, Regional Offices and Primary Care Trusts.

Redaction and disclosure of material provided

11.27 The Panel's Terms of Reference included a commitment that it would oversee maximum possible disclosure of relevant information. This was the core guiding principle in the approach to any redaction of the material to be made available.

11.28 The Redaction Framework was intended to ensure, as far as possible, a consistent and thorough approach. Organisations that provided large volumes of material to the Panel were given access to the document management system so that they could apply their own redactions in line with the agreed framework. The Redaction Framework stated that redactions could only be applied for the following reasons:

- personal or personally sensitive data
- legal professional privilege
- information provided in confidence.

11.29 Contributing organisations and individuals suggested the redactions that they felt were justified within the framework. Where, on review, the Panel felt that the redactions could not be justified, stakeholders were asked to reconsider. While the Panel had no status in law to enforce disclosure and therefore had, in some exceptional cases, to accept redaction where it did not feel it was warranted, the position of the Panel was made clear to the stakeholders concerned. Further comment is made about this issue later in this chapter.

11.30 As the work of the Panel came to a conclusion, organisations and individuals were asked to carry out one final search, and to certify that this had been done and that all material that might be relevant to the work of the Panel in the context of its Terms of Reference had been made available. Copies of these certificates are available on the Panel website. Some organisations and individuals did not respond to this requirement. They are listed below:

- BBC
- Kiran Bhogal
- Care Quality Commission
- Chichester Crematorium
- DAC Beachcroft
- Hampshire County Council
- Tony Horne
- The *Independent*
- ITV
- Legal Aid Agency
- Ministry of Defence
- Patrick Sadd
- Portchester Crematorium
- Royal College of Nursing
- Thames Valley Primary Care Agency

11.31 As noted above, a key guiding principle of the Panel was 'families first'. It was fundamental to the Panel that the process of public disclosure was managed so that disclosure was made initially to the affected families. The Panel decided that it should disclose its Report fully to the families on the day of publication but in advance of the Report becoming available to

any other person or to the media or to the general public. As a result, the Panel was committed to a policy of 'no piecemeal disclosure'.

How the Panel reviewed material

11.32 Families in contact with the Panel, some of whom had provided documents, were asked to formulate questions that would help to focus and inform the Panel's work. The Panel's work was shaped but not defined by receiving and understanding these questions. They helped the Panel to approach its work through a series of themes, reflecting the nature of the unanswered questions rather than responding to each individual case.

11.33 The following themes emerged from the Panel's approach:

- clinical care and practice
- clinical governance
- scrutiny – focusing on police investigations
- regulatory – focusing on the role of regulatory bodies
- the role of the media
- the role of the local MP.

As is noted in paragraph 2.96, the Panel's analysis was formulated through privileged access to medical records and supporting documentation granted to the Panel alone. As such, the process has not involved any other party.

How organisations and individuals helped the Panel's analysis

11.34 No organisation or individual approached by the Panel who held material refused to disclose it unredacted to the Panel for review, with the exception of Dr Jane Barton, whose solicitor told the Panel that a box of documents would not be disclosed on the basis that it attracted legal professional privilege.

11.35 A number of organisations and individuals who did disclose material to the Panel argued that some of it could not be disclosed publicly because to do so would amount to a breach of legal professional privilege. In these cases, the Panel sought to encourage the relevant authority to waive privilege in the public interest and to enable the Panel to deliver maximum possible public disclosure, in line with its Terms of Reference. The Panel is grateful to a number of authorities, including Portsmouth Hospitals NHS Trust, who have agreed to do so.

11.36 In the case of documents regarded by the Department of Health and Social Care as attracting legal professional privilege, agreement was eventually reached that privilege should be waived exceptionally on relevant documentation, in order to give the families and the public an opportunity to understand the Department's involvement in the aftermath of events at the hospital. The Panel notes that this does not set a precedent for future waiver of legal and professional privilege by the Department of Health and Social Care. The Panel was concerned, however, that this agreement was reached close to the date of publication of the Panel's Report. More generally, the Panel notes that organisations tend to approach the issue of legal and professional privilege on the basis of considering whether it could be applied, rather than whether it should be applied, having regard to the public interest. The Panel believes that there are lessons from this experience for future inquiries.

11.37 In one or two other cases, there have been shortcomings in the assistance given to the Panel by relevant organisations. In particular, the Panel's experience with the General Medical

Council suggests that there are lessons to be learnt in ensuring that organisations understand the guidance issued by the Panel on redactions and the process to be followed, including how it is interpreted and managed by the organisation concerned.

11.38 In the case of Hampshire Constabulary, the Panel was concerned to discover that there were gaps in the material it had expected to find relating to major investigations. For example, Hampshire Constabulary was unable to provide the minutes from Gold Group meetings that should and would have taken place throughout all the police investigations.

11.39 The Panel is of the view that these minutes must have existed at some time and it is unable to understand what happened to these documents. Despite repeated requests and reportedly exhaustive searches, they have not been found nor has any record of their destruction been established.

11.40 The Panel's work has also identified other gaps in the material provided. Most significantly, it is inexplicable that the Panel should not have been provided with three boxes of Portsmouth HealthCare NHS Trust Board papers and related documents. Chapter 4 highlights the gap.

11.41 Chapter 3 refers to another gap. From 1989, there is evidence of complaints that relate to four key areas of concern: hydration and nutrition; general nursing care; medical care; and use of opioid analgesia at a dose that made patients drowsy. The Panel has established that a box of documents relating to complaints received by Portsmouth HealthCare NHS Trust was destroyed in 2013 ahead of its scheduled review date. That material could not therefore be assessed by the Panel.

11.42 The Panel is concerned about both these sets of missing material: the three boxes of Trust Board papers and the further box of documents covering complaints. The Panel does not consider it acceptable to leave this situation unresolved. The Panel looks to the Department of Health and Social Care to investigate further and to report publicly on its findings.

11.43 The work of the Panel has revealed a poor level of record keeping and information management in a number of organisations, including Hampshire Constabulary. Even where those organisations have sought to be helpful, it is apparent that they do not know the documents they hold and where they are housed. As a result, locating these documents has been a significant challenge for the Panel. More importantly, the Panel's experience demonstrates that there is a need for higher standards of information management across the public sector. This is not just a matter of good housekeeping. In reality, public bodies cannot be accountable in the way they should be if their records cannot be readily accessed or, in some cases, cannot even be found. The Panel therefore looks to the Government to recognise this as a crucial element of governance and accountability, and to take action accordingly.

11.44 The Panel looked to a number of organisations and individuals who had provided documents for review to help with a process of factual accuracy checking. Those involved were provided with sections of text, describing their documents, in a confidential reading room and were not given hard copy or electronic access outside the room. The organisations and individuals were not shown the Panel's Report because the Panel's Terms of Reference require the Panel to manage disclosure initially to the affected families. The Panel invited and considered written comments based on factual accuracy.

11.45 Over and above the factual accuracy checking process, the Department of Health and Social Care raised the issue of any further representation process. In fact, the Panel had

considered this issue at a very early stage. The Panel is a non-statutory inquiry, whose Terms of Reference were agreed by the Department of Health and Social Care. The Panel has held no public hearings, gathered no evidence and conducted no interviews. This has been a purely document-based review. Stakeholder organisations have been asked to certify that they have provided the Panel with all relevant material. On this basis, the Panel has been able to consider all material on each issue pertinent to its Terms of Reference and to demonstrate what the documents disclose in each case. The Panel is not empowered to determine issues and, thereafter, to direct any level of explicit criticism towards any individual. The Panel's Report engages in a demonstration of what the documents show. As such, it is not engaging in 'explicit or significant' criticism. The Panel has followed the precedent devised by the Hillsborough Independent Panel. The Panel would like to place on record its appreciation of the efforts made by organisations and individuals who have assisted the Panel as described in this chapter, particularly those who were cooperative from the outset, understood the environment in which the Panel was working and sought to support it with openness and transparency. These include the Portsmouth Coroner, the General Register Office for England and Wales, the Care Quality Commission, Professor Richard Baker and Professor Brian Livesley.

11.46 By contrast, the Panel asks a number of organisations and individuals to reflect on their conduct in relation to the Panel's work. Although not a statutory inquiry, Ministers announced the Gosport Independent Panel to Parliament. In so doing, the Government made it clear that there remained unanswered questions for the families about the care of their relatives, their treatment and death and the progress of the various investigations. The Panel encountered some cases where those involved wished to engage on their own terms rather than the Terms of Reference announced to Parliament; for example, the solicitor instructed by Portsmouth Hospitals NHS Trust.

Specific and wider conclusions

11.47 In the course of its work, the Panel has highlighted how the information reviewed adds to public understanding of what happened at the hospital and the aftermath of the events. These conclusions are described in Chapter 12.

Table 5: Contributing organisations and individuals

Original organisation/individual	Successor/legacy organisation/individual
Action against Medical Accidents	
Ann Alexander, Alexander Harris Solicitors	Irwin Mitchell LLP
Professor Richard Baker	
BBC	
Kiran Bhogal, solicitor	
Blake Lapthorn Claims LLP	
Chichester Crematorium	
Commission for Health Improvement (CHI)	Care Quality Commission (CQC)
Council for Healthcare Regulatory Excellence (CHRE)	Professional Standards Authority
Crown Prosecution Service (CPS)	
DAC Beachcroft LLP	

Original organisation/individual	Successor/legacy organisation/individual
Department of Health	Department of Health and Social Care
Caroline Dinenage, MP for Gosport 2010–present	
Lucy Docherty, Chair of Fareham and Gosport Primary Care Trust	
Dr Christopher Dudley	
Professor Robin Ferner	
Professor Gary Ford	
Professor Robert Forrest	
Forton Medical Centre	
General Medical Council (GMC)	
Gosport Borough Authority	Gosport Borough Council
Gosport War Memorial Hospital	Managed by: Southern Health NHS Foundation Trust Portsmouth Hospitals NHS Trust
Hampshire and Isle of Wight Strategic Health Authority	NHS England
Hampshire Constabulary	
Hampshire County Council	
Hampshire Registrars	General Register Office for England and Wales (GRO)
Health Authorities, including Regional Health Authorities, Primary Care Groups, Primary Care Trusts	Fareham and Gosport Clinical Commissioning Group
Mark Hoban, MP for Fareham 2001–2015	
Tony Horne, Chief Executive of East Hampshire Primary Care Trust	
The *Independent*	
Independent Complaints Advocacy Service	SEAP Hampshire
Information Commissioner's Office (ICO)	
Institute of Naval Medicine (INM)	
ITN	ITN/ITV
Nina Lakhani, journalist	
Dr Peter Lawson	
Tom Leeper, Counsel for four families	
Legal Services Commission (LSC)	Legal Aid Agency (LAA)
Professor Brian Livesley	
Stephen Lloyd, MP for Eastbourne 2017–present	
Ed Marsden, independent consultant	
James Mehigan, solicitor	

Original organisation/individual	Successor/legacy organisation/individual
Mills & Reeve LLP (Portsmouth HealthCare NHS Trust solicitors)	
Ministry of Justice	
National Clinical Assessment Service (NCAS)	
NHS Litigation Authority (NHSLA)	
NHS South Central Strategic Health Authority	NHS England
NHS South of England Strategic Health Authority	NHS England
Office of Hampshire Police and Crime Commissioner	
Andrew Pate, reporter with Meridian TV	
David Perry QC	
Ian Piper, Chief Executive Officer of Fareham and Gosport Primary Care Trust; Operational Director, Portsmouth HealthCare NHS Trust	
Police Complaints Authority (PCA)	Independent Police Complaints Commission (IPCC)
Portchester Crematorium	
Portsmouth Archives	
Portsmouth Coroner	
Portsmouth News	
Royal College of Nursing (RCN)	
Royal Hospital Haslar	Ministry of Defence
Patrick Sadd, solicitor	
Margaret Scott, Chair of East Hampshire Primary Care Trust	
Sky News	
Smiths Medical	
Thames Valley Primary Care Agency	
United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)	Nursing and Midwifery Council (NMC)
Wessex Local Medical Committees	
Gerardine Whitney, Community Tutor for Continuing Education	

Table 6: Organisations and individuals contacted but no material provided

Original organisation/individual	Successor organisation
Attorney General's Office	
BBC Radio Solent	
BBC South Today	
Bindmans LLP	
Bishop of Portsmouth	
Professor David Black	
British Geriatrics Society (BGS)	
British Medical Association (BMA)	
Raymond Burt, Hampshire Constabulary	
Cabinet Office	
Channel 5	
Citizens Advice Bureau	Citizens Advice
Clinical Governance Support Team	
Complaints held by Health Authorities and hospitals	Ombudsman
Confederation of Health Service Employees (COHSE)	Unison
Gareth Cruddace, Chief Executive of Hampshire and Isle of Wight Strategic Health Authority	
Trevor Daniel	
Frank Dobson, former MP	
Doctors4Justice	
Professor Sir Liam Donaldson, former Chief Medical Officer	Department of Health and Social Care
Eastbourne Herald	
Councillor Peter Edgar, Hampshire County Council	
Fareham Borough Authority	Fareham Borough Council
General Pharmaceutical Council (GPhC)	
Lord Goldsmith	
Gosport Archives	
Gosport War Memorial Hospital League of Friends	
Hampshire Ambulance Service	South Central Ambulance Service
Hampshire Partnerships NHS Trust	Southern Health NHS Foundation Trust
Hampshire Police Authority	
Hampshire Primary Care Trust	NHS England
HM Inspectorate of Constabulary (HMIC)	

Original organisation/individual	Successor organisation
Home Office	
Lesley Humphrey, Director of Quality at the Portsmouth HealthCare NHS Trust	
Lord Hunt	
James Kenroy, Portsmouth Coroner until May 2003	
Norman Lamb MP	
Richard Maddison, Hampshire Constabulary	
Alan Milburn, former MP	
Max Millett, Chief Executive of Portsmouth HealthCare NHS Trust	
Stephanie Morgan, Hampshire Constabulary	
Dr Anne Naysmith	
Dr Peter Old, Director of Public Health for Portsmouth and South East Hampshire Health Authority	
Dr Michael Petch OBE	
Police Federation	
Police Superintendents' Association	
Portsmouth and South East Hampshire Community Health Council	Healthwatch
Portsmouth Council	
Press Council and Press Complaints Commission	Independent Press Standards Organisation (IPSO)
Queen Alexandra Hospital	Portsmouth Hospitals NHS Trust
Royal College of General Practitioners (RCGP)	
Toni Scammell, senior nurse	
Baroness Scotland	
Shropshire Star	
Jacqui Smith, former MP	
Southern Daily Echo	
Dr Jane Tandy	
Dr Simon Tanner, Director of Public Health for Hampshire and Isle of Wight Strategic Health Authority	
Dr Michael Taylor, independent consultant	
Treasury Solicitors	Government Legal Department
Sir Peter Viggers, MP for Gosport 1974–2010	
Malcolm Wells, photographer, *Portsmouth News*	
Dr Andrew Wilcock	

Part IV

How the Report adds to public understanding

Chapter 12: Summary and conclusions

Introduction and key conclusions

12.1 In waiting patiently for the Panel's Report, the families of those who died at Gosport War Memorial Hospital ('the hospital') will be asking: "Have you listened and heard our concerns, and has the validity of those concerns been demonstrated?"

12.2 It is over 27 years since nurses at the hospital first voiced their concerns. It is at least 20 years since the families sought answers through proper investigation. In that time, the families have pleaded that *"the truth must now come out"*. They have witnessed from the outside many investigative processes. Some they have come to regard as *"farce"* or *"cover-up"*. Sometimes they have discovered that experts who had found reason for concern had been ignored or disparaged. Sometimes long-awaited reports were not published.

12.3 The Panel has now completed its work. It has listened and heard the families' concerns and interrogated documents and personal medical records – including over one million pages of documents – which in their entirety had not previously been independently reviewed.

12.4 Having looked at documents covering the whole period since 1987, the Panel can say: "Yes, we have listened and yes, you, the families, were right. Your concerns are shown to be valid." Indeed, as this Report shows, the practice of anticipatory prescribing and administering opioids in high doses affected many patients and families – not only those who have led the way in pressing for the truth, but also very many other families.

12.5 Opioids are powerful drugs that bring significant benefits when used appropriately, but they carry commensurate risks. The Panel's analysis demonstrates that the lives of very many people were shortened as a direct result of the pattern of prescribing and administering opioids that had become the norm at the hospital.

12.6 For the initial group of 163 patients drawn to the attention of the Panel (**the Initial Group**), clinical records or key parts of them were not available in 58 cases. For the remaining 105 patients, the Panel found that in 71 cases there was evidence that opioids were used without appropriate clinical indication.

12.7 The starkness of this finding raised immediate concern that other patients, of whom we were not initially aware, might also have been affected. The Panel therefore sought all the clinical records for the 2,024 patients whom it was aware had died in the hospital between 1987 and 2001. The Panel found hospital records for 1,564 of these patients, and examined them for evidence of opioid use without appropriate clinical indication. In 1,043 of these patients (**the Wider Group**), there was sufficient information available for the Panel.

12.8 In 385 of the Wider Group of patients, the Panel found evidence of opioid use without appropriate clinical indication.

12.9 In summary, the Panel found evidence of opioid use without appropriate clinical indication in 456 patients. The Panel concludes that, taking into account the missing records, there were probably at least another 200 patients similarly affected but whose clinical notes were not found.

12.10 The Panel's analysis therefore demonstrates that the lives of over 450 people were shortened as a direct result of the pattern of prescribing and administering opioids that had become the norm at the hospital, and that probably at least another 200 patients were similarly affected.

12.11 In short, during the period between 1989 and 2000 at Gosport War Memorial Hospital, which appears to cover the start and end of the pattern of opioid prescribing of concern, the disclosed documents reveal that:

- There was a disregard for human life and a culture of shortening the lives of a large number of patients.
- There was an institutionalised regime of prescribing and administering *"dangerous doses"* of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.
- When the relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions.
- The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.

12.12 Relatives of patients at the hospital could have hoped that those responsible for healthcare would have identified what had happened, or that the various investigations conducted since they sounded the alarm would have done so. This Report has described how many experts were called upon to offer their opinion. However, none of them had access to the full range of medical records.

12.13 The families, and indeed the nation as a whole, are entitled to ask how these events could have happened; how the hospital dismissed the nurses' concerns and subsequently took no action; how the healthcare organisations failed to intervene; how the professional regulators allowed matters to continue; how the police failed to get to the bottom of what had happened; and whether what happened is to be explained as a conspiracy or in some other way.

12.14 From the documents it has examined, the Panel has been able to answer many of these questions as set out in this chapter. The Panel's Terms of Reference did not extend to any hospital other than Gosport War Memorial Hospital, then or now. So the Panel cannot speculate on whether anything similar to what happened at Gosport War Memorial Hospital also happened elsewhere.

12.15 It is not the Panel's role to ascribe criminal or civil liability. The Secretary of State for Health and Social Care and the relevant public authorities will want to consider the action that now needs to be taken to further investigate what happened at the hospital. The Secretary of

State will want to ensure that families who believe they were affected by events at the hospital have the support they deserve going forward, and also to consider wider lessons.

Summary of the chapters

12.16 The Terms of Reference require the Panel to explain how the documents it has considered add to public understanding of what happened at the hospital. Each of the chapters in this Report concludes by identifying those points of public understanding that can now be seen clearly and for the first time.

12.17 The Panel has interrogated the documents. Each chapter of this Report describes what the documents say about what happened at the hospital and how the responsible authorities chose to respond. The chapters explain what is added to public understanding in the case of the hospital and each of those authorities.

12.18 Chapter 1 shows that, following concerns first raised by Anita Tubbritt (a staff nurse working on Redclyffe Annexe), Sylvia Giffin, a fellow staff nurse, wrote to their manager in February 1991 expressing concern over the prescribing and use of drugs with syringe drivers.

12.19 The documents the Panel has reviewed show that between then and January 1992, a number of nurses raised concerns about the prescribing specifically of diamorphine. In doing so, the nurses involved, supported by their Royal College of Nursing branch convenor, put the hospital in a position from which it could have rectified the practice. In choosing not to do so, the opportunity was lost, deaths resulted and 22 years later it became necessary to establish this Panel in order to discover the truth of what happened. The documents therefore tell a story of missed opportunity and warnings unheeded.

12.20 Chapter 2 describes the drugs that were prescribed, including diamorphine, and the pattern of anticipatory prescribing that became the norm at the hospital. The occurrence of opioid use without appropriate clinical indication followed a clear pattern over time. We found no instances of this in 1987 or 1988, but from 1989 the number of cases rose markedly and then reached a plateau between 1994 and 1998. This was followed by an equally striking decline over 1999 and 2000, with no instances in 2001. Within the period 1989 to 2000, lives were shortened to the extent described in Chapter 2, see Figure 2, and earlier in this chapter.

12.21 Chapter 3 uses case studies to illustrate the experience of patients and relatives at the hospital. As well as confirming the pattern of prescribing and administration of drugs, Chapter 3 demonstrates the sub-optimal care and lack of diligence by nursing staff in executing their professional accountability for the care delivered. Patients and relatives were marginalised and their interests became subordinate to those of the professional staff.

12.22 Chapter 4 shows how the relevant healthcare organisations failed to recognise what was happening at the hospital and failed to act to put it right.

12.23 Chapter 5 sets out how Hampshire Constabulary dealt with the allegations made by the families, the shortcomings of the investigations, and the cases that were presented to the Crown Prosecution Service. The chapter explains that, although the investigations were protracted, they were limited in their depth and in the range of possible offences pursued. The documents show the involvement of senior officers including at chief officer level. The chapter also describes the response of the CPS, including the limitations in considering the possibility of corporate liability and health and safety offences.

12.24 The GMC's primary purpose is to protect patients. Chapter 6 shows that concerns about the hospital were brought to the attention of the GMC in 2000. It also describes the circumstances that meant there was a ten-year delay before the GMC's Fitness to Practise Panel considered sanctions against Dr Jane Barton, clinical assistant at the hospital.

12.25 The NMC's main objective is to safeguard the health and well-being of people using or needing the services of its registrants. Chapter 7 demonstrates a similar pattern with the NMC as the statutory regulator for nurses. From the point of referral to its predecessor body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in 2000, it would take ten years for the Preliminary Proceedings Committee to decline to proceed in respect of all the allegations against the nurses concerned.

12.26 Chapter 8 shows how the Coroner and Assistant Deputy Coroner proceeded with inquests nearly two years after the Crown Prosecution Service had decided not to prosecute.

12.27 Chapter 9 describes how the local and national media covered concerns about the hospital from April 2001 onwards. This was over two and a half years after Gillian Mackenzie and others contacted Hampshire Constabulary, thereby setting in motion the police investigation. The documents illustrate the sometimes close relationship between the police and the media, and how the police and healthcare organisations made contact with each other when the media raised questions.

12.28 Chapter 10 describes how Sir Peter Viggers, the local MP, questioned the need for repeated inquiries into what had happened at the hospital.

12.29 Chapter 11 describes the work of the Panel in delivering its Terms of Reference, and sets out the Panel's concerns about standards of record keeping and missing material.

Wider conclusions

12.30 In reviewing the documents for the respective chapters, the Panel has been able to draw upon the specialist expertise of Panel members relating to the prescribing and administering of drugs, medicine for the elderly, nursing skills and care for older people, the healthcare and regulatory systems, the police and prosecutions, the coronial system, government and the media. The chapters of this Report explain how the documents reviewed add to public understanding. In this final chapter, the Panel has been able to piece together the picture that has emerged, to look across the material as a whole and to answer the questions that have arisen.

12.31 The practice of anticipatory prescribing, and of administering certain drugs in circumstances and doses beyond what would have been indicated or justified clinically, involved the consultants, the clinical assistant, the nurses and the pharmacists. It was a practice that built up and continued over many years, and lives were shortened before the pattern changed significantly from 2000. Some nurses had questioned the practice in 1991, but it continued, becoming a culture and a norm for the wards involved. It became institutionalised on the wards.

12.32 One of the most difficult things to understand about these events is why so many people were prescribed and administered drugs that were not clinically indicated, in quantities sufficient to shorten their lives. The documents indicate two striking features. First, anticipatory prescribing was used on the basis that medication might become necessary at a time when the doctor covering a ward was unable or unwilling to attend in order to prescribe it. The documents show that inappropriate use of opioids not clinically justified became more and more common

over the years up to 1994, and persisted until 1998. This created a situation where powerful and potentially lethal medication was available for a large number of patients, and was expected to be used at some point.

12.33 The second feature of note is a pattern of clinical judgements being made that patients were close to death, regardless of the purpose of their admission or the plan in place. The documents show that these judgements were often not justified clinically and did not take into account patients' or families' views.

12.34 It may be tempting to view what happened at the hospital in the context of public debate over end of life care, what a 'good death' is, and assisted dying. That would be a mistake. What happened at the hospital cannot be seen, still less justified, in that context. The patients involved were not admitted for end of life care but often for rehabilitation or respite care. The pattern of prescribing and administering drugs was excessive and inappropriate in the ways explained in this Report.

The failure to act on the nurses' concerns: what is revealed as to how no one at the hospital listened to those concerns and intervened

12.35 The documents show that some nurses raised concerns in 1991. Their warnings went unheeded. The Panel has considered what the documents reveal about why those in authority at the hospital did not listen effectively.

12.36 It is clear from the documents disclosed that others in the hospital had knowledge of the way that powerful medications were used and the consequential shortening of lives. Most obviously, there was the attempt by some of the nurses to raise concerns, but other individuals should also have been aware of what was happening, including consultants, other doctors, nurses and managers. Yet a striking feature of the documents is that no one attempted even to challenge these behaviours.

12.37 The documents point to an explanation in a further aspect of the culture at the hospital. Part of that culture was a legacy of the concept of 'clinical freedom'. This held that medical decisions could not be questioned by other clinicians and managers, because they were based solely on individual professional judgement. In theory, this should have been entirely supplanted by evidence-based practice, but in many places this was slow to happen, and the documents suggest that it did not happen in the hospital in the period in question. While there should have been an accepted practice of challenge, for example from the nurses (beyond those who challenged in 1991), that was not the prevailing culture. Indeed, in accepting the medical judgement made most often by the clinical assistant, the consultants effectively supported rather than challenged the practice of prescribing and the nurses were themselves involved.

12.38 Towards the end of the 1990s, the culture of challenge should have been reinforced by the advent of clinical governance, which made clinicians and managers accountable for the quality of clinical care, crucially including patient safety. Again, this was slower to take effect in some places than others, and the disclosed documents show that this was the case in the hospital. The failure of the executive directors, including the medical director, to respond effectively to concerns about opioid prescribing raised by an external consultant physician who provided an independent report in 1999 is instructive in illustrating the rudimentary state of clinical governance at the hospital.

12.39 The disclosed material makes it clear that, notwithstanding the explanations of persistent notions of 'clinical freedom' and ineffective clinical governance, there were ample signs of problems that were serious enough to have overridden any concerns over professional boundaries.

12.40 Seen from this perspective, the events surrounding the nurses' concerns of 1991 can be put into the correct context. Raising the concerns in the first place was a brave act given the culture at the hospital. There is evidence in the documents that the nurses felt ostracised as a result. After an unsatisfactory meeting at which the nurses were faced with an intimidating array of other staff, including doctors, the documents show that the nurses were dismissively told to take any future concerns up directly with the doctor whose practice they had reason to challenge. This placed the nurses in a position where the only means of pursuing their reservations was to confront, unsupported, an individual in a professionally dominant position.

12.41 The documents show that the nurses raised clear concerns in 1991, but these were ignored. From the perspective of 2018, it is hard to understand how such serious matters could be so easily discounted.

12.42 Those who raise concerns about the conduct and practice of colleagues are now widely known as 'whistle-blowers'. To put it into context, it is generally agreed that the NHS has not been good at protecting people who take such a difficult step; as the documents make clear, the events of 1991 were no exception. Nor should the consequences for whistle-blowers be underestimated: these commonly included disciplinary action and undermining of professional credibility.

12.43 There is a wider point. The documents relating to the hospital correspond with evidence elsewhere in the health system and indeed in other sectors: organisations simply do not listen to what their frontline staff have to say. This is despite the fact that those members of staff see what is happening very clearly and can gauge its impact in practice, not least from engaging with members of the public, in this case patients and relatives.

12.44 If those responsible for the hospital had listened properly to what their own nurses said in 1991, and acted, the Panel is clear that the events described in this Report would not have followed the path they did. This should serve as a challenge to all those in positions of authority.

The response of individuals and organisations: what is revealed about healthcare organisations and their interaction with the police and regulatory organisations

12.45 The failure to heed the nurses' warnings meant that, for many years, there was no effective challenge to what was happening at the hospital. When that challenge did come from the families, the documents reveal a pattern of response that even then did not focus on their concerns or effectively address them.

12.46 The documents show that, following a complaint to the Trust in 1998 and the police investigation, it should have become clear to local NHS organisations that there was a serious problem with services at the hospital. Although the successive police investigations undoubtedly complicated the NHS response, it is nevertheless remarkable that at no stage was there a public admission of failure or any public apology. Nor was there a proportionate clinical investigation into what had happened. On the contrary, the documents show numerous instances of defensiveness and denial – to families, to the public and the media, and to health service and other organisations.

12.47 In the years following the re-emergence of serious concerns about the hospital, beginning in 1998, many NHS organisations had knowledge of at least part of the picture: Health Authorities, Primary Care Groups and Trusts, the regional office of the NHS Executive, the Commission for Healthcare Improvement and the Department of Health. Despite this, the documents make clear that no external organisation was able to intervene effectively to find out what had happened, to ensure that corrective action was taken, and to give the answers that the families and the public should have had many years ago.

12.48 As this Report has shown, many disparate organisations were involved from 1998, and especially from 2000, spanning the health and justice systems. Between them, as is now clear from the documents, they failed to identify the nature of the underlying problem or to deal with it effectively. It is understandable that the families in particular have sought explanations as to why this was the case. There are two broad possibilities.

12.49 First, each organisation may have acted in its own interests and those of its leaders, motivated by reputation management, career self-preservation and taking the path of least resistance. This coincidence of interests would itself lead to identical responses across organisations, without there being a conspiracy between the organisations.

12.50 The second possibility is that there was collusion – a conspiracy between organisations to ensure that the views of the families were consistently frustrated. It is not clear what the underlying motivation would be for such a course, but it is understandable that the almost uniform consistency with which all concerns were dismissed and families were rebuffed might lead to suspicions of collusion or conspiracy between organisations.

12.51 The documents the Panel has reviewed do not contain evidence in support of such collusion or conspiracy. They show that the underlying explanation is the tendency of individuals in organisations, when faced with serious allegations, to handle them in a way that limits the impact on the organisation and its perceived reputation. This does not diminish the importance or the impact of organisations acting similarly and prioritising compliance with their own processes. Too readily opting for what is convenient within an organisational setting is the enemy of recognising the real significance of concerns and allegations.

12.52 The Panel is able to say in this case that there was a coincidence of interests across organisations; and that this may well have been sufficient to explain their conduct, including at times their dismissive treatment of the families.

12.53 Instead of listening to the families objectively, the documents speak of a tendency to dismiss them as troublemakers. For example, as Chapter 5 demonstrates, within a week of meeting two relatives, a detective constable wrote: *"I have no idea why these 2 sisters are so out to stir up trouble".*

The response of individuals and organisations: what is revealed about focusing on an individual 'rogue doctor' following Shipman

12.54 A perception rapidly took root with both the police and NHS bodies external to the Trust that Dr Barton might be a 'rogue doctor' or 'lone wolf', operating surreptitiously and without authorisation. It is impossible to miss the significance of the relatively recent conclusion to the Harold Shipman case at the time, and there are several references, direct and oblique, to the Shipman case in documents briefing Ministers. It is notable that the Chief Medical Officer selected Professor Richard Baker to carry out the external audit of deaths in significant part because he had carried out a similar audit in connection with the Shipman investigation.

12.55 This perception, that the events might be due to 'another Shipman', cast a long shadow. Hence, even in 2007 when the final police investigation concluded, the obvious next step seemed to be to resume the GMC professional regulatory process against Dr Barton. The culmination of that process clearly dissatisfied many, including the GMC's Chief Executive. However, the outcome was at least in part due to the exclusive focus on one individual when there were significant systemic problems – as the proceedings began to reveal – as well as the length of time that had elapsed by then.

12.56 It is clear from the documents that awareness of the Shipman case cast a shadow over how concerns at the hospital were viewed. Shipman was first arrested in September 1998. Whether for that reason or for some other reason, the police focused on the allegation that Dr Barton was guilty of unlawful killing, rather than pursuing a wider investigation. Hampshire Constabulary approached Dr Barton's managers, including the then Chief Executive at the Trust, and Dr Althea Lord, the responsible consultant, in a way that ignored the possibility that they too might have been subject to investigation.

The response of the police: what is revealed about their approach and priorities

12.57 Chapter 5 reveals the approach taken by Hampshire Constabulary throughout its three investigations. It is no surprise to the Panel that the police approach failed to satisfy the families from the start. The documents show that the quality of the police investigations was consistently poor.

12.58 From the start, the mindset was one of seeing the family members who complained as stirring up trouble, and seeing the hospital, by contrast, as the natural place to go for guidance and assurance. As such, the police did not attempt to conduct enquiries in the same way as they would have done in a different setting; that is, one not involving medical decisions and treatment given in a hospital. The documents show that the police viewed the allegations as matters for the Trust and the regulatory bodies.

12.59 In reviewing the documents, the Panel has been mindful of how police forces set their priorities for investigation and for resources. In particular, in the period covered by this Report, both national and local targets informed that process of prioritisation. There are no documents referring to any decisions within Hampshire Constabulary to place less emphasis on their investigations into the hospital than on other activities that would have scored against any such targets. However, the Panel notes that organisations tend to favour acting in ways that are relevant to how they are measured or judged.

12.60 More generally, the evidence in this case suggests that, faced with concerns amounting to allegations of unlawful killing in a hospital setting, there are clear difficulties for police investigation. It is not clear to the Panel how the police can best take forward such investigations, and how they are to know whose advice to seek from within the health service without compromising their enquiries. This is particularly significant if the problem concerns the practice on a ward where more than one member of a clinical team is involved. It is a need that calls for action across different authorities, rather than a matter for the police service in isolation.

The response of individuals and organisations: what is revealed about wrongly relying on professional regulatory bodies

12.61 This exclusively individual focus by the police led to a continuation of the bar on investigating or sharing results pending completion of the regulatory process, in order to prevent the case being jeopardised. It also reinforced the perception that there were no systemic

issues to be addressed locally and thus no further reason to investigate. This, however, reflects a prevalent but incorrect view of the function of professional regulators like the GMC. Their function is neither to investigate systemic health service failures nor to punish errant doctors; rather, it is to protect the public by regulating the current fitness to practise of registered medical practitioners. Hence, even though the GMC found that there had been impairments to Dr Barton's fitness to practise, strictly speaking it was entitled to find that she was not a danger to patients by the time the hearing had been completed. The distress caused to families by the outcome of the GMC proceedings arose in part from the exclusive reliance of NHS bodies on the GMC, when it was not in fact an appropriate sole mechanism.

The response of individuals and organisations: what is revealed about suspending effective action pending police investigation

12.62 The documents illustrate the effect of the police investigations on all the external health service organisations. All concerned assumed not only that the police investigations took priority, but that they prevented any other investigations from proceeding. There were only two exceptions: the management investigation into the actions of managers who had failed to admit knowledge of the nurses' dossier (which was halted after its initial phase because another police investigation was under way) and the Baker Report (which was entirely records-based and could be carried out without requiring wider knowledge of the findings). Otherwise, not only were no investigations commissioned, but it appears (from their responses) that most NHS organisations were reluctant even to mention the problem.

12.63 This has been a common occurrence when police investigations into NHS services take place, and there are valid concerns. If interviewees are asked about events, if they talk to others and if they see or hear potential findings, their evidence would be regarded as contaminated by prior knowledge if a case came to court. The documents in this case make clear that at several points the police communicated this view and its attendant warning widely to national and regional health service bodies. It is clear that none wanted to risk any possible subsequent case being thrown out because they had failed to observe this precaution.

12.64 When the police investigations subsequently concluded without prosecutions, this bar was removed. It is notable, however, that there was still no effective NHS action. There are some obvious reasons for this, although none fully explains the failure to grasp a problem of this magnitude and significance.

The response of individuals and organisations: what is revealed about the use of experts

12.65 As noted earlier in this chapter, and in Chapters 4 to 8, a number of experts were engaged, including by the police, the NHS, the Chief Medical Officer and the Coroner. The documents show that none of these experts had access to the full range of medical records to which the Panel has had access, and they are therefore not responsible for the failure of the full picture to appear clearly until now. A more detailed review of the use of the experts is available at the Expert Overview on the Gosport Independent Panel website (https://gosportpanel.independent.gov.uk/expert).

12.66 The documents reveal weaknesses in how the experts were commissioned: there was sometimes no clarity on their remit and insufficient focus on the relevant specialist expertise required.

12.67 At times, the documents reveal a misuse, not just of the experts' opinions, given in good faith, but of the experts themselves. This, along with the poor standards in commissioning experts and making use of their contribution, points to a need for a more professional framework for the use of experts.

Completion of the Panel's Terms of Reference

12.68 The Panel understands the further deep anger and frustration of the families that none of the investigations effectively revealed the truth of what had happened. The Panel has listened to the families and the documents now disclosed enable that truth to emerge.

12.69 Nothing in this Report can restore to the families their loved ones whose lives were shortened. With this Report and an online archive of documentation, the Panel has completed its Terms of Reference. The Panel now calls upon the Secretary of State for Health and Social Care and the relevant investigative authorities to recognise the significance of what is revealed by the documentation in this Report and to act accordingly.

June 2018

Appendices

Appendix 1: Further background

A1.1 This appendix provides further background to the Report.

A1.2 The first part gives information about the Panel's analysis of the prescribing and administration of drugs at Gosport War Memorial Hospital ('the hospital'). This information complements and explains the number of deaths described in Chapter 2 and in Table 1.

A1.3 The second part describes the General Medical Council (GMC) and its processes. This information may be helpful in understanding Chapter 6 of the Report.

The Panel's analysis: further information

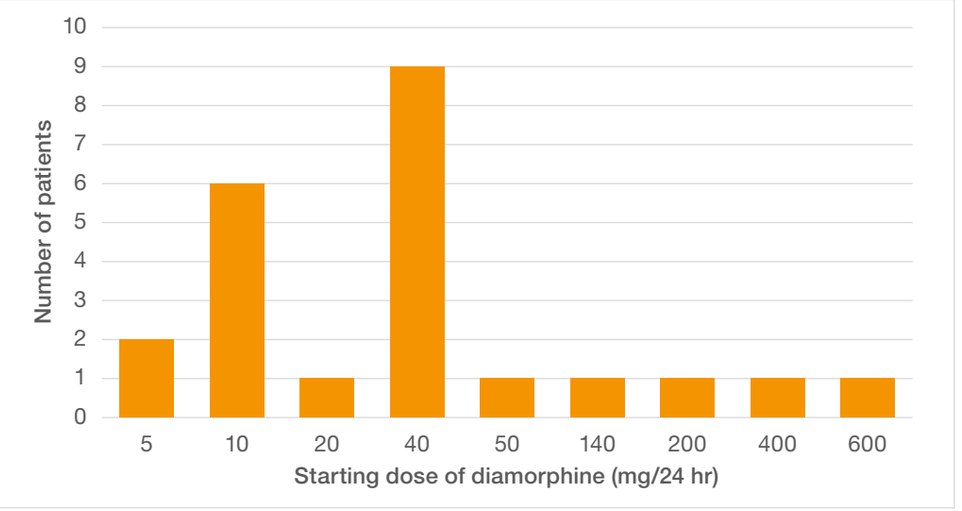
A1.4 The Panel's Terms of Reference (see Appendix 3) require the Panel through its Report to provide an overview of the information reviewed and to illustrate how the information disclosed adds to public understanding of events at the hospital and their aftermath. In order to do so, the Panel has reviewed the documents secured in the way described in Chapter 11 and overseen maximum possible public disclosure via this Report and the accompanying website. In addition, the Panel has been able to consider the clinical records and death certificates for those patients who died at the hospital between 1987 and 2001.

A1.5 The Panel's Report brings together its review of this range of documents. Chapter 2 explains the Panel's resulting analysis of the pattern of prescribing and administering drugs. The Panel started by reviewing the information available for the 163 patients in the **Initial Group**. The picture emerging led the Panel to examine a **Wider Group** of 1,043 patients, where sufficient records were available. Chapter 2 highlights the number of deaths of patients from this group where opioids were prescribed and administered without appropriate clinical indication.

A1.6 The analysis of the Wider Group, as well as the analysis of the Initial Group, is clearly fundamental to the Panel's Report. Accordingly, it may be helpful to provide further information about how the analysis of the Wider Group relates to the analysis of the Initial Group. In a random selection of 30 patients from the Wider Group, the Panel performed an analysis identical to that completed for the Initial Group. The Panel found that 23 of these 30 patients (77%) received continuous diamorphine through a syringe driver. Of these 23 patients, nine of them had not previously received diamorphine orally or another opioid such as fentanyl before the diamorphine was commenced through a syringe driver. These nine patients were therefore opioid naïve.

A1.7 Figure 12 shows the starting dose of diamorphine for these 23 patients. As in the Initial Group, the diamorphine starting dose is excessive in the majority of patients in this sample.

Figure 12: Starting dose of diamorphine for 23 patients from the Wider Group



A1.8 Six of the 23 patients received oral morphine before the opioid dose was escalated to continuous and subcutaneous diamorphine by syringe driver. To maintain dose equivalence, the dose of subcutaneous diamorphine should be between 33% and 50% of the oral morphine dose. From this sample, one patient received a dose of diamorphine eight times the final dose of oral morphine. These findings again confirm that the dosages of opioids used at the hospital far exceeded normal conventional practice.

A1.9 This further information is illustrative of the detailed work the Panel conducted in relation to the 30 patients in the Wider Group. The Panel has concluded that its examination of this group demonstrates that opioid use in this group showed the same features as those in the Initial Group of patients.

The General Medical Council and its processes

Introduction

A1.10 The GMC was established by the Medical Act 1858. Its primary role is to protect patients (GMC000504, p7). In 2002, the Medical Act 1983 was amended to insert section 1A, which stated: *"The main objective of the General Council in exercising their functions is to protect, promote and maintain the health and safety of the public"* (GMC101215, p211). The GMC is the only body that can erase a doctor from practice, or suspend or place conditions upon a doctor's right to practise in the UK.

A1.11 On 9 December 2004, the fifth report from the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*,[1] was published. The GMC investigation into the events at Gosport War Memorial Hospital spanned a number of reforms. In large part, these reforms were in response to criticism arising from the Shipman Inquiry.

A1.12 Concerns about the events at the hospital were first brought to the attention of the GMC in 2000. The only doctor whose case was taken to a fitness to practise hearing was Dr Jane Barton. Her case was heard between 2009 and 2010.

1 HM Government, 2002. *The Shipman Inquiry. Fifth report, Safeguarding Patients: Lessons from the Past – Proposals for the Future*. http://webarchive.nationalarchives.gov.uk/20090808160144/http://www.the-shipman-inquiry.org.uk/fifthreport.asp (accessed 17 May 2018).

Evolution of the GMC's processes

A1.13 The GMC is an umbrella organisation. It is responsible for regulating doctors. Different bodies within the organisation receive complaints, investigate those complaints and decide if hearings should be held to consider whether interim or full orders should be made in relation to a doctor's registration. Until the formation of the Medical Practitioners Tribunal Service in June 2012, the GMC also held those hearings and made the decisions.

A1.14 The composition of these different bodies within the overall GMC, and the rules under which they operate, were the subject of fundamental change during the investigation into the events at the hospital.

Fitness to practise rules prior to 1 November 2004

A1.15 Prior to 2004, there were separate rules dealing with the different aspects of doctors' fitness to practise, depending on whether the concerns about their practice related to conduct, health or performance (GMC101025, pp171–209).

A1.16 The nature of the case would determine which of the GMC committees would consider the case.

A1.17 **Conduct:** All the investigations arising from events at the hospital were related to the conduct of the doctors, and so were considered as conduct cases.

A1.18 Conduct cases would be considered by the Preliminary Proceedings Committee and then, if there was determined to be sufficient concern, the case would be referred to the Professional Conduct Committee.

A1.19 A case relating to conduct is one where *"a question arises whether conduct of a practitioner constitutes serious professional misconduct"*.[2]

A1.20 **Performance** cases would be considered by the Assessment Referral Committee and then, if applicable, by the Performance Assessment Committee.

A1.21 **Health** cases would be considered by the Health Committee.

Initial screening prior to 1 November 2004

A1.22 A case against a doctor would begin with the receipt of a complaint or information in writing to the Registrar.

A1.23 The Registrar would submit the matter to a Medical Screener, if it appeared that a question arose as to whether the conduct of a practitioner constituted *"serious professional misconduct"*.[3]

A1.24 The second stage was the consideration of the case by the Medical Screener.

2 1988 Professional Conduct Rules, Rule 2(1).
3 1988 Professional Conduct Rules, Rule 6(1).

A1.25 In 2001 and 2002, when screening decisions were in the process of being taken in this investigation, the Screeners were appointed by the President of the GMC.[4]

A1.26 At that time, the Medical Screener had to refer the case to the Preliminary Proceedings Committee, unless the Medical Screener decided that the question of whether or not the practitioner's conduct constituted serious professional misconduct did not arise.

A1.27 If the Medical Screener took this view, the case then had to be considered by a Lay Screener and the case could only be 'screened out' if the Lay Screener agreed with the Medical Screener's decision.[5] If the Lay Screener did not agree, the case would be referred to the Preliminary Proceedings Committee.

Preliminary Proceedings Committee prior to 1 November 2004

A1.28 Between 1996 and 1 July 2003, the Preliminary Proceedings Committee had seven members. The Chair was appointed by the Council. The six other members were appointed in accordance with GMC rules,[6] to ensure that the committee had four elected members, one appointed member and two lay members.

A1.29 At Preliminary Proceedings Committee hearings there had to be a minimum of five members present, including at least one lay member.

A1.30 In January 2001, the GMC issued guidance that said:

> "In conduct cases the Preliminary Proceeding Committee's task is to decide whether, in its opinion, there is a real prospect of serious professional misconduct being established before the Professional Conduct Committee. Serious professional misconduct may be considered in the context of conduct so grave as potentially to call into question a practitioner's registration whether indefinitely, temporarily or conditionally."[7]

A1.31 When referring a case to the Professional Conduct Committee, the Preliminary Proceedings Committee had to indicate the matters which, in its opinion, appeared to raise the question of whether the practitioner had committed serious professional misconduct and which formed the basis of a charge or charges.

A1.32 Rule 11(2) was used by the GMC in the case against Dr Barton:[8]

> "When referring a case to the Professional Conduct Committee the Committee shall indicate the convictions, or the matters which in their opinion appear to raise a question whether the practitioner has committed serious professional misconduct, to be so referred and to form the basis of the charge or charges;

4 1988 Professional Conduct Rules, Rule 4; HM Government, 2002. *The Shipman Inquiry. Fifth report, Safeguarding Patients: Lessons from the Past – Proposals for the Future*. http://webarchive.nationalarchives.gov.uk/20090808160144/http://www.the-shipman-inquiry.org.uk/fifthreport.asp (accessed 17 May 2018), paragraphs 19.2 and 19.21–19.23.

5 1988 Professional Conduct Rules, Rule 3(A).

6 GMC (Constitution of FTP Committees) Rules 1996, Rule 3(1).

7 HM Government, 2002. *The Shipman Inquiry. Fifth report, Safeguarding Patients: Lessons from the Past – Proposals for the Future*. http://webarchive.nationalarchives.gov.uk/20090808160144/http://www.the-shipman-inquiry.org.uk/fifthreport.asp (accessed 17 May 2018), paragraph 20.147.

8 1988 Professional Conduct Rules, Rule 11(2).

> Provided that, where the Committee refer any case relating to conduct to the Professional Conduct Committee and the Solicitor (or the complainant) later adduces grounds for further allegations of serious professional misconduct of a similar kind, such further allegations may be included in the charge or charges in the case, or the evidence of such grounds for further allegations may be introduced at the inquiry in support of that charge or those charges, notwithstanding that such allegations have not been referred to the Committee or formed part of the subject of a determination by the Committee."

A1.33 Once the case against a doctor had been referred to the Professional Conduct Committee, Rule 11 allowed further matters of a similar kind to be added to the original case referred by the Preliminary Conduct Committee.

Professional Conduct Committee prior to 1 November 2004

A1.34 From 1996 to 1 July 2003, there were 23 medical members and seven lay members on the Professional Conduct Committee. All members of the committee were also members of the Council itself.

A1.35 Hearings had to be heard by at least five members; at least one had to be a lay member. Members of the Professional Conduct Committee could not also be members of the Preliminary Proceedings Committee.

A1.36 In 2000, the Constitution Rules were amended to reduce the minimum number of members on a panel to three, including at least one medical and one lay member.

A1.37 From 1 July 2003 to 1 November 2004, the 2003 Transitional Rules applied to the constitution of the Professional Conduct Committee. They stated that *"membership of each of the fitness to practise committees [which included the Professional Conduct Committee] shall comprise of doctors and lay persons appointed to each of those committees by the Council and included on lists of persons for each of those committees maintained by the Council"*. Members of the Council could still sit as members of the Professional Conduct Committee.

Procedure during Professional Conduct Committee hearings prior to 1 November 2004

A1.38 A Professional Conduct Committee hearing would begin with the practitioner being asked if they accepted any or all of the facts alleged in the charges.[9]

A1.39 If the practitioner did not accept all the facts, evidence would be called to allow the committee to determine whether any of the facts were proved. Once the panel had decided which facts had been found proved or admitted, it then considered whether or not those facts would be *"insufficient to support a finding of serious professional misconduct"*.[10]

A1.40 If the facts were insufficient, then the case would proceed no further.

A1.41 If it was decided that the facts were not insufficient to support a finding of serious professional misconduct, the Panel went on to consider whether or not there had been serious professional misconduct.

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9 Part V of the 1988 Rules set out the procedures.

10 1988 Professional Conduct Rules, Rule 27(2).

A1.42 The committee Chair would then invite the Solicitor or Complainant to address the committee as to: (i) the circumstances leading to those facts; (ii) the extent to which such facts are indicative of serious professional misconduct; and (iii) the character and previous history of the practitioner. The practitioner would then be invited to put forward any mitigation.

A1.43 The committee would then determine whether it found the practitioner to have been guilty of serious professional misconduct.

A1.44 If the committee found the practitioner guilty of serious professional misconduct, it would consider whether to make a *"direction"* immediately, or postpone that decision.[11]

A1.45 If the Professional Conduct Committee found a doctor guilty of serious professional misconduct, it could direct that conditions be placed on the doctor's registration, or order a suspension of his or her practising certificate, or order the practitioner's erasure from the register.

A1.46 If the committee decided to make a direction, Rule 31 of the 1988 Rules set out that it had to consider the available sanctions in this order:

- Is conditional registration sufficient to protect members of the public or is it in the practitioner's interests?
- If conditions would not be sufficient, would it be sufficient to direct that the practitioner's registration shall be suspended?
- If suspension would not be sufficient, the committee would direct erasure.

Legal framework after 1 November 2004

A1.47 On 1 November 2004, new rules came into force which fundamentally changed the way allegations against doctors were considered and determined. Although there have been further amendments and changes since, the general framework introduced in November 2004 has remained.

A1.48 Previously, in a conduct case, the panel had had to decide if there had been *"serious professional misconduct"*.[12]

A1.49 The General Medical Council (Fitness to Practise) Rules 2004 introduced the concept of *"impaired fitness to practise"*. Rather than engaging separate rules (and separate panels) for cases of conduct, performance and health, the question now was whether the doctor's fitness to practise was *"impaired"*.

A1.50 Screeners and the Professional Conduct Committee were replaced with Case Examiners and the Investigation Committee.

Investigation Committee and Case Examiners

A1.51 As before, a case is considered first by a Registrar. If the Registrar decides that the allegation falls within circumstances which mean that a doctor's fitness to practise could be regarded as impaired, the case is investigated.

11 1988 Professional Conduct Rules, Rule 30.
12 1988 Professional Conduct Rules, Rule 29.

A1.52 The case is referred to a Medical Case Examiner and a Lay Case Examiner to decide how to proceed. Case Examiners are officers of the Council.

A1.53 Case Examiners can: direct that the allegation should not proceed further; issue a warning to the doctor; refer the allegation to the Investigation Committee to consider the appropriate outcome; refer the allegation for determination by a Fitness to Practise Panel (or Medical Practitioners Tribunal after June 2012); or invite the doctor to comply with undertakings.

A1.54 The Case Examiners set out in writing all the matters that they have taken account of, and full reasons for the decision that they take.

A1.55 Considerable guidance is now given to the Investigation Committee and Case Examiners on the types of practice or behaviour that may result in a finding of impaired fitness to practise by the GMC. That guidance is available on the GMC website.[13]

1 November 2004 to 31 December 2015 – procedure of Fitness to Practise Panel

A1.56 Members of the GMC did not sit on Fitness to Practise Panels.

A1.57 Where the facts alleged by the GMC were disputed by the doctor, evidence was called and the panel would consider and announce its findings of fact.

A1.58 Once the facts had been determined, the Fitness to Practise Panel would consider whether the doctor's fitness to practise was impaired. This process could involve the calling of further evidence and the making of submissions.

A1.59 If the panel decided that the doctor's fitness to practise was impaired, it would receive further evidence and hear further submissions. It would then decide if a sanction or warning should be imposed.

A1.60 The panel could: direct that a doctor's registration become conditional; order a suspension of his or her practising certificate; or order the practitioner's erasure from the register.

A1.61 The GMC did not have a direct right of appeal for any decision that it considered to be too lenient or that did not protect the public. The GMC had to make representation to the Council for Healthcare Regulatory Excellence, which would consider the case and decide if an appeal to the High Court should be made.

Transitional Provisions

A1.62 Cases referred by the Preliminary Proceedings Committee before 1 November 2004 were covered by the Transitional Provisions (GMC101125, pp263–8). These set out that the cases would be heard applying the 'old rules' (GMC101068, pp211–22). In other words, the rules that had been in place at the time when the doctor had been referred.

A1.63 Cases put before a Registrar after 1 November 2004 would be considered as set out above and heard applying the new rules.

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13 MPTS/GMC, 2017. *Sanctions guidance*. www.mpts-uk.org/DC4198_Sanctions_Guidance_Feb_2018_23008260.pdf (accessed 18 May 2018).

1 January 2016 to present – Medical Practitioners Tribunal

A1.64 The Shipman Inquiry's Fifth Report was not alone in criticising the lack of independence caused by the fact that Fitness to Practise Panel members came under the umbrella of the GMC.

A1.65 In an email dated 22 July 2011, Niall Dickson, GMC's Chief Executive, said that he was not responsible for selecting panel members. He stated:

> "… under the current arrangements we establish a process which is independently overseen. Panellists are appointed by open competition against certain identified competencies. Although these are not public appointments, the recruitment process is carried out in line with guidance issued by the Office of the Commissioner for Public Appointments. The process is overseen and evaluated by an independent assessor recommended by the Appointments Commission. Under our proposed reforms a senior judge will head up the new tribunal service and he or she will be responsible for the recruitment process and for performance managing panelists. Our frustration with the existing system is that the panels are autonomous (and rightly so) but we cannot challenge their decisions." (GMC100022, p13)

A1.66 On 1 January 2016, the Fitness to Practise Panels were replaced with Medical Practitioners Tribunals.

A1.67 Tribunal members are medical and lay people appointed by the Medical Practitioners Tribunal Service. This was set up in 2012 and is independent of the GMC.

A1.68 A tribunal must consist of at least three members, including one lay and one medical member.

A1.69 The general framework for referral to the Medical Practitioners Tribunal and the conduct of hearings has remained largely unchanged.

A1.70 There are rights of appeal against a final decision made by the Medical Practitioners Tribunal for doctors, the GMC and the Professional Standards Authority. These appeals are heard in the High Court and are governed by the Civil Procedure Rules 1998.

Time limit for bringing cases

A1.71 The 1988 Civil Procedure Rules set out that cases could not be referred to the Preliminary Proceedings Committee if, at the time the complaint was first made to the Council, more than five years had elapsed since the events giving rise to that allegation.

A1.72 However, a Medical Screener could direct that a case be referred to the Preliminary Proceedings Committee, if *"the public interest requires this in the exceptional circumstances of that case"*.

A1.73 This remained the case until December 2015, when the requirement for *"exceptional circumstances"* was removed. Now, the test is whether proceedings are in the public interest.

Interim orders

A1.74 Before August 2000, interim orders could only be made by the Preliminary Proceedings Committee. These could be for a maximum of six months, but could be renewed for up to three months.

A1.75 The Interim Orders Committee was established in August 2000 as a direct result of the public concern caused by the GMC's inability to act in the case of Harold Shipman, despite the fact he had been arrested on a charge of murder.[14]

A1.76 A case had to be considered by a Screener before it could be referred to the Interim Orders Committee.

A1.77 Screeners have now been replaced by Case Examiners, who provide full written reasons for their decisions.

A1.78 The Interim Orders Committee (now replaced with Interim Orders Tribunals) had the task of deciding whether it was necessary to suspend a doctor's registration or to impose conditions on a doctor's registration, pending a final decision in the case.

A1.79 Interim orders are imposed if it is necessary to protect the public, in the public interest or in the doctor's interest.

A1.80 Interim orders can be imposed for a maximum of 18 months, after which time they must be reviewed in the High Court.

Voluntary erasure

A1.81 When a doctor ceases work in the UK (due to retirement etc), they usually seek to come off the GMC register in a process called *"voluntary erasure"*.[15]

A1.82 If a doctor is under investigation, the GMC will carefully consider whether to allow voluntary erasure to take place.

A1.83 Once a doctor has been erased, the GMC has no jurisdiction and can take no action. The GMC considers many factors, for example that a doctor may wish to reapply for inclusion on the register in the future and the investigation that should have taken place will not have done so.

Revalidation

A1.84 In the wake of the Shipman Inquiry, the GMC brought in *"revalidation"* from 3 December 2012.[16]

A1.85 Under this process, all licensed doctors are required to demonstrate on a regular basis (every five years) that they are up to date and fit to practise in their chosen field and able to provide a good level of care.

A1.86 Mr Dickson described revalidation as *"the biggest thing that has been attempted in the last 150 years"* (GMC000270, p1). He explained that, before revalidation came into force, the GMC register simply recorded the historical qualification obtained by a doctor.

A1.87 At the time of the events at the hospital, the GMC had no process of revalidation.

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14 HM Government, 2002. *The Shipman Inquiry. Fifth report, Safeguarding Patients: Lessons from the Past – Proposals for the Future*. http://webarchive.nationalarchives.gov.uk/20090808160144/http://www.the-shipman-inquiry.org.uk/fifthreport.asp (accessed 17 May 2018), paragraph 16.86.

15 GMC (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations 2003.

16 GMC (Licence to Practise and Revalidation) Regulations 2012 s1(1).

Appendix 2: Detailed patient case studies

Case Study – Arthur Cunningham

Summary of hospital admission

- In 1998, Arthur Cunningham was aged 79. He was a widower who lived in a nursing home.
- On 21 July 1998, he was admitted to Mulberry Ward at Gosport War Memorial Hospital, due to renovations at his nursing home.
- On 28 August, he was discharged back to his nursing home.
- On 21 September, he was reviewed by Dr Althea Lord, a consultant geriatrician, at Dolphin Day Hospital who noted a *"large necrotic sacral ulcer which was extremely offensive"* and admitted Mr Cunningham directly to Dryad Ward, Gosport War Memorial Hospital, for active treatment of his sore. His nursing home was requested to keep his place open for a period of two to three weeks as he was expected to return there.
- On 26 September, Mr Cunningham died.

Background, care and treatment

Mr Cunningham was diagnosed with Parkinson's disease, dementia, reactive depression, diet controlled diabetes and myelodysplasia; he also had an old pelvic injury. Mr Cunningham was experiencing hallucinations and dystonic movements caused by his medication. His mobility was poor and although he could walk he also used a mobility scooter and wheelchair to aid mobilisation. Historically, Mr Cunningham had lived in supported accommodation but by June 1998 he was living in a nursing home and was a regular visitor to Dolphin Day Hospital, Gosport War Memorial Hospital, under the care of Dr Althea Lord.

In June 1998, Mr Cunningham scored 23/29 on a mini mental state examination (MMSE) and was described as well presented and speaking in full sentences. At that time he had expressed dissatisfaction about where he lived, had found it difficult to give up his independence and had refused to return to his accommodation; therefore, new accommodation was arranged at a nursing home.

On 21 July, Mr Cunningham was admitted to Mulberry Ward at Gosport War Memorial Hospital because renovations were taking place at his nursing home. His mental and physical states were assessed on admission and noted on a daily basis. The clinical notes record that he had mild dysarthria, was cooperative and eating independently. He was quiet, with mumbling speech, although his vocabulary appeared normal. He was physically frail with a Parkinson's tremor in his left arm, some muscle wasting of the left leg and power of 4/5 in both arms. He had some back pain, needed minimal assistance with personal care and was good at transferring himself from bed to chair. He had some urinary incontinence and needed catheterisation. His mood was

said to be variable because he was experiencing frustration and unhappiness with his lack of independence; at times, he experienced paranoia and hallucinations.

On 27 August, Dr Lord reviewed Mr Cunningham and noted that his Parkinson's was a little worse, he was less mobile and there had been a deterioration in renal function; however, he was eating better, had put weight on and his mood had improved. Dr Lord confirmed her view that he should be discharged the next day. On 28 August, Mr Cunningham was discharged to his nursing home. The discharge record noted Mr Cunningham's creatinine value to be 301.

On 11 September, Mr Cunningham was noted to have settled well into the nursing home.

On 18 September, Mr Cunningham was reviewed by the community psychiatric nurse who noted that he had *"settled well into [the nursing home]. There have been no real management or behavioural problems. He can be awkward at times but mostly he is pleasant and compliant. His mood seems good."*

On 21 September, Mr Cunningham was reviewed by Dr Lord at Dolphin Day Hospital. She noted a *"large necrotic sacral ulcer which was extremely offensive … his Parkinson's disease doesn't seem any worse and he was less depressed but continues to be very frail".* Dr Lord admitted Mr Cunningham directly on to Dryad Ward at Gosport War Memorial Hospital with a detailed note that included plans for active treatment of his sore. His nursing home was requested to keep his place open for a period of two to three weeks as he was expected to return there. Dr Lord noted *"prognosis poor"*. She prescribed morphine oral solution 2.5–10 milligrams (mg), as required, four hourly, to be administered prior to dressing his sacral sore. Mr Cunningham was administered 5 mg of morphine oral solution at 14:50 and 10 mg at 20:15.

Dr Jane Barton, clinical assistant, also recorded in the clinical notes: *"Transfer to Dryad Ward. Make comfortable. Give adequate analgesia. I am happy for nursing staff to confirm death."* Dr Barton prescribed diamorphine 20–200 mg, midazolam 20–80 mg, hyoscine 200–800 micrograms, subcutaneously, as required, over 24 hours. At 23:10, 20 mg of diamorphine and 20 mg of midazolam were initiated and administered by continuous subcutaneous infusion.

The nursing notes record the administration of diamorphine and midazolam and note: *"peaceful following"*. The nursing care plan records that Mr Cunningham took two glasses of milk while awake.

Panel comments – Box 1

- The Panel has not seen any document in the clinical records to confirm Dr Barton's rationale for prescribing diamorphine and midazolam at this stage.
- The Panel notes that Mr Cunningham was opioid naïve.
- The Panel notes the wide dose range of diamorphine which was prescribed in a patient who had renal impairment.

In relation to the prescription for diamorphine and midazolam, Dr Barton stated in an interview with Hampshire Constabulary in April 2005:

> "I was concerned that although the [morphine oral solution] would assist in providing pain relief, this might become inadequate. The sacral sore was very significant, being the size of a fist, and the second largest I have ever seen. It was clearly causing [Mr Cunningham] significant pain and distress at the time when I assessed

him. Accordingly, I decided to write up diamorphine on a proactive basis and a dose range of 20 to 200 mgs. This was a wide range, but I was conscious that inevitably the medication would be commenced at the bottom end of this range, if given at all. Any increase would then ordinarily be with reference to me or another practitioner. In addition to the diamorphine I prescribed 200 - 800 mcgs of Hyoscine and 20 - 80 mgs Midazolam. These medications were prescribed by me purely with the aim of alleviating [Mr Cunningham's] significant pain, distress and agitation … I have no specific recollection, but I anticipate that the second dose of [morphine oral solution] had been insufficient in relieving the pain and anxiety, and in the circumstances, to ensure that [Mr Cunningham] was free from pain and anxiety, and had a settled and an uninterrupted night, the Diamorphine was then commenced, providing continuous pain relief for what was clearly a most unpleasant ulcerated wound … I cannot now say if I was specifically contacted about the institution of the diamorphine. Ordinarily I would have been contacted, but the administration was at the lowest end of the dose range, and its provision had been agreed with me and the nursing staff earlier, so it is possible that specific reference was not made."

In 2009, Dr Barton told the General Medical Council (GMC) Fitness to Practise (FtP) hearing:

"… first of all, I was aware of how very ill he was and that he would possibly very shortly be on an end-of-life pathway rather than purely palliative care. I was also aware when I saw him at the Day Hospital with Dr Lord that there had been problems with his tablets, difficulty swallowing them, and that if we were going to give adequate analgesia we might well need to give this subcutaneously rather than as tablets or orally. I know he had taken milk overnight but his eating and drinking, and his taking of tablets, was possibly a bit suspect … In my opinion, he was then on a palliative care pathway. We had to keep him comfortable. That depth and size of sore must have been very uncomfortable and very distressing for him, particularly when it was dressed and seen to … My priorities were that I was aware that he was very ill, very frail and I was going to keep him comfortable … There was a remote possibility that with adequate protein drinks, with proper local treatment to the sore, it might improve, but I had never in my clinical career seen one survive. My course of treatment was exactly as it would have been, even if I thought we could heal the sore. I was minded to keep him comfortable, reduce any anxiety and distress he may have had. I was not considering him at that point in that afternoon as being terminal. I was, however, aware that he had just finished a course of antibiotics issued by the Day Hospital and that despite that the sore was very much worse, so I was not very optimistic about his prognosis but I was not going to do anything to hasten his death or to his detriment."

Dr Barton also told the FtP hearing:

"In my opinion there were two main reasons for starting the syringe driver. My advice to my day staff, when I saw Mr Cunningham that afternoon, would have been, Start with the [morphine oral solution], but you do have a pro-active prescription for the syringe driver should his distress and pain deteriorate and you feel you are going to be able to manage it with oral medication. Both the diamorphine and the midazolam would have been ideal medication to control his discomfort, distress, anxiety overnight, as well as the pain he was receiving … So that was what the pro-active prescription was for."

Panel comments – Box 2

- Dr Barton did not record the explanations she provided to the police or to the FtP hearing in Mr Cunningham's clinical notes at the time of her assessment.

On 22 September 1998, the nursing notes record:

> "[Son] has telephoned. Explained that syringe driver containing diamorphine, midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode when Mr Cunningham tried to wipe sputum on a nurse saying he had HIV and was going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself."

At 20:20, 20 mg of diamorphine and 20 mg of midazolam were administered subcutaneously as a 24-hour infusion. The nursing notes record: *"Driver running as per chart. Very settled night."*

On 23 September, the nursing notes record that Mr Cunningham was seen by Dr Barton and that *"he has become chesty overnight to have hyoscine added to driver… son informed of deterioration … asked if this was due to the commencement of the syringe driver … informed that [Mr Cunningham] was on small dosage which he needed."*

The syringe driver set up the evening before was paused and hyoscine added; there is no record on the drug chart that any remaining drug was discarded. At 09:25, the syringe driver was restarted with diamorphine 20 mg, midazolam 20 mg and hyoscine 400 micrograms to be administered over 24 hours.

At 13:00, the clinical records note that Mr Cunningham's son was:

> "… very angry that syringe driver has been commenced. It was explained yet again that the contents of the syringe driver were to control his pain. It was also explained that the consultant would need to give her permission to discontinue the driver and we would need alternative method of giving pain relief … now fully aware that [Mr Cunningham] is dying and needs to be made comfortable."

The drug chart further records *"discarded"* on the 09:25 diamorphine dose and, at 20:00, the administration of 20 mg of diamorphine, 60 mg of midazolam and 400 micrograms of hyoscine was commenced.

Panel comments – Box 3

- The Panel notes that the syringe driver was renewed at 20:00 with an increased dose of midazolam.
- The Panel has not seen any document in the clinical records to confirm the rationale for the three-fold increase in the dose of midazolam commenced at 20:00 on 23 September.
- The Panel feels that in light of the reported anxiety of Mr Cunningham's son, an appointment with a consultant should have been made.

In her police interview, Dr Barton stated:

> "I anticipate that Mr CUNNINGHAM'S agitation might have been increasing, hence the increase in the level of Midazolam, and indeed in spite of that, the notes go on to record that Mr CUNNINGHAM became a little agitated at 11 p.m. with the syringe

> driver being boosted with effect. The nursing staff recorded that Mr CUNNINGHAM seemed to be in some discomfort when moved, and the driver was boosted prior to changing position. Again, I anticipate that I would have been contacted about the increase in the medication and agreed with it, though I have got no recollection of this."

During the FtP hearing, Dr Barton stated:

> "This would have been the picture of a man whose pain relief seemed adequate, so the diamorphine was kept at the same level but that he was becoming now terminally restless. This would have been in association with the bronchopneumonia he was now developing, hence the reason for administering the hyoscine and also increasing the midazolam. We wanted reduction of anxiety. There must be nothing worse than listening to your secretions in your throat and not being able to clear them, and also a muscle relaxant for him … [this was] adequate sedation to make him comfortable during this terminal phase of his life not excessive sedation, but adequate, so that he was not frightened and anxious as he approached death."

Panel comments – Box 4

- Dr Barton did not record the explanations for the three-fold increase in midazolam she provided to the police or to the FtP hearing in Mr Cunningham's clinical notes at the time of her assessment.

The nursing notes record: *"Became a little agitated at 23:00hrs, syringe driver boosted with effect. Seems in some discomfort when moved, driver boosted prior to position change."* The notes further record that Mr Cunningham's catheter was draining but the urine was very concentrated.

Panel comments – Box 5

- The Panel notes that the 23:00 boost was not recorded in the drug chart. The Panel has not seen any record to confirm the magnitude of the increase in dose.

On 24 September, the nursing notes record that Mr Cunningham was in pain when attended to, and that the diamorphine, midazolam and hyoscine had been increased at 10:55.

The drug chart confirms that at 10:55 Mr Cunningham was commenced on diamorphine 40 mg, midazolam 80 mg and hyoscine 800 micrograms by syringe driver over 24 hours.

Dr Barton assessed Mr Cunningham and recorded in the clinical notes: *"Remains unwell. Son has visited again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death."*

Panel comments – Box 6

- The Panel has not seen any document in the clinical records to confirm the rationale for the two-fold increase in the dose of diamorphine and hyoscine and the one-third increase of midazolam.

In her police interview, Dr Barton stated:

> "[The nurse] recorded a report from the night staff that Mr CUNNINGHAM was in pain when being attended to, and was also in pain with the day staff, though it was suggested that this was especially in his knees. In any event, the syringe driver was increased to 40 mgs of Diamorphine, and the Midazolam to 80 mgs, together with 800 mcgs [micrograms] of Hyoscine."

During the FtP hearing, Dr Barton said that nurses had informed her that Mr Cunningham was becoming tolerant of the diamorphine and she needed *"to increase the dose a little bit to give him the same level of comfort".*

Panel comments – Box 7

- Dr Barton did not record the explanations for the increase in dosage she provided to the police or to the FtP hearing in Mr Cunningham's clinical notes at the time of her assessment.

On 25 September, Dr Sarah Brook, a GP in Dr Barton's practice who assisted at the hospital, recorded in the clinical notes: *"remains very poorly on syringe driver, for TLC".*

Dr Barton wrote another prescription increasing the ranges for diamorphine to 40–200 mg, midazolam 20–200 mg and hyoscine 800 micrograms–2 gm.

The drug chart records that, at 10:15, diamorphine 60 mg, midazolam 80 mg and hyoscine 1,200 micrograms were administered by syringe driver over 24 hours.

Panel comments – Box 8

- The Panel notes that there was an error in the prescribed dose of hyoscine, which was written as mg rather than mcg (micrograms).
- The Panel has not seen any document in the clinical records to confirm the rationale for the increase in the prescribed dose range.

In her police interview, Dr Barton stated:

> "I anticipate that in the usual way I would have seen Mr CUNNINGHAM again that morning, 25th September. I wrote a further prescription for the Diamorphine, Hyoscine and Midazolam, this time with the ranges being 40 - 200 mgs, 800 mcgs - 2 grams, and 20 - 200 mgs respectively. It appears then that the Diamorphine was increased to 60 mgs, with 90 mgs of Midazolam and 1200 mcgs of Hyoscine at 10.15 that morning. My expectation is that this increase was necessary to relieve Mr CUNNINGHAM'S pain and distress. It is likely that by this time Mr CUNNINGHAM would have been becoming tolerant to opiates, and that might have added to the need to increase the doses of medication."

During the FtP hearing, Dr Barton stated that she did not see Mr Cunningham on this day.

Panel comments – Box 9

- Dr Barton did not record the explanations for the increase in the prescribed doses she provided to the police in Mr Cunningham's clinical notes at the time of her assessment.

- The Panel has not seen any document in the clinical records to confirm the rationale for the increased dose of diamorphine and hyoscine.

On 26 September, the drug charts confirm that at 11:50 diamorphine 80 mg, midazolam 100 mg and hyoscine 1,200 micrograms were given by syringe driver over 24 hours.

Panel comments – Box 10

- The Panel has not seen any document in the clinical records to confirm the rationale for the increase in diamorphine and midazolam.
- In her police interview, Dr Barton stated: *"I anticipate that Mr CUNNINGHAM was experiencing further pain and distress, necessitating the increase, and that Dr BROOK would have agreed with it, though it is also possible that I might have been contacted prior to the increase by the nursing staff instead. In view of Mr CUNNINGHAM'S condition, with the significant pain from the large sacral sore, and the fact that he would have been becoming inured to the medication, that increase would have been necessary."*
- During the FtP hearing, Dr Barton confirmed that 26 September was a Saturday, that she did not see Mr Cunningham on this day and that she assumed he would have been seen by the duty doctor.
- Dr Barton did not record the explanations for the increase in the prescribed doses she provided to the police in Mr Cunningham's clinical notes at the time of her assessment.

The clinical records note that, on 26 September: *"[Mr Cunningham's] condition continued to deteriorate [and he] died 23:15."*

Nursing care plans were created for 'assistance to sleep', 'large sacral sore', 'blister on heel', 'assistance with personal hygiene' and 'catheterised'.

Panel comments – Box 11

- At the time of Mr Cunningham's admission, guidance from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) (see Bibliography) emphasised the requirement for nurses to work in an open and cooperative manner with patients and their families. In this regard, the Panel has seen no documents in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Mr Cunningham's family.
- At the time of Mr Cunningham's admission, accountability was an integral part of nursing practice. Nurses were accountable for their actions, and inactions, at all times. The relevant nursing professional codes of conduct and standards required nurses to scrutinise a prescription; question any ambiguity in the prescription: where they believed it necessary, refuse to administer a prescription: and report to an appropriate person or authority any circumstances which could jeopardise the standards of practice or any concern about health services within their employing Health Authority or Trust. The codes and guidance made it clear that to silently tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and contrary to personal professional accountability. The Panel has not seen any document to confirm that nurses treating Mr Cunningham challenged the proactive and repeated high and wide dose range prescription of diamorphine, midazolam and hyoscine. The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines to scrutinise the doses; nor did they question any of the consultants, doctors or the pharmacist at Gosport War Memorial Hospital in respect of the prescription and doses.
- The Panel notes that the relevant nursing codes of conduct and standards provided that, when administering or overseeing the administration of drugs, nurses should be able to justify and be accountable for any actions taken.
- The Panel has not seen any nursing document in the clinical records to show the reason or rationale for the decision to commence and continue the use of diamorphine and midazolam.

- The Panel has not seen any nursing document in the clinical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of diamorphine and midazolam.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of diamorphine and midazolam.
- At the time of Mr Cunningham's admission, the UKCC guidance required nurses to carry out a comprehensive assessment of the patient's nursing requirements, and devise, implement and keep under review care plans. The UKCC guidance also required nurses to create and maintain medical records in order to provide accurate, current, comprehensive and concise information concerning the condition and care of the patient. Such records would include: details of observations, problems, evidence of care required, action taken, intervention by practitioners, patient responses, factors that appeared to affect the patient, the chronology of events, and reasons for any decision. These records would provide a baseline against which improvement or deterioration could be judged. Among other elements of care, *"Through their role in drug administration nurses are in an ideal position to monitor the drugs progress, reporting responses and side effects"*. In this regard, the care plans seen by the Panel were limited in detail, were not personalised to the patient's needs and did not take account of Mr Cunningham's capabilities, likes, dislikes and preferences. The Panel found no pain charts or pain management plans in Mr Cunningham's clinical records. It is not clear to the Panel how Mr Cunningham's pain and the effectiveness of any analgesia were to be adequately monitored.
- The Panel has not seen any fluid charts or nutrition plan among Mr Cunningham's clinical records. Fluid and nutritional intake was an important part of the clinical picture. Diamorphine and midazolam could impair the ability to eat and drink.
- In addition to its intended effects, morphine might also have a number of side effects on a patient, including agitation and respiratory depression. The Panel has not seen any document in the clinical records to show that the nurses treating Mr Cunningham understood or took into account these possible side effects of morphine when noting Mr Cunningham's condition. In this regard, the relevant nursing codes of conduct and standards required nurses to take every reasonable opportunity to maintain and improve knowledge and competence, including understanding the substances used when treating a patient.

Case Study – Elsie Devine

Summary of hospital admission

- In 1999, Elsie Devine was aged 88 and lived with her daughter and her family.
- On 9 October, she was admitted to Queen Alexandra Hospital. In the days before admission she had become confused and aggressive and had been found wandering.
- On 20 October, she was deemed to be *"suitable for a rehabilitation programme"* and fit for discharge.
- On 21 October, she was admitted to Gosport War Memorial Hospital for rehabilitation.
- On 15 November, she became restless and aggressive and on 18 November a locum staff psychiatrist from the Department of Elderly Mental Health assessed her and noted: *"This lady has deteriorated and has become much more restless and aggressive again. She's refusing medication and not eating well."*
- On 21 November 1999, Mrs Devine died on Dryad Ward at Gosport War Memorial Hospital at 20:30.

Background, care and treatment

In 1999, Mrs Devine was aged 88. She had one daughter and one son and lived with her daughter and her family. Mrs Devine had lost her husband 21 years earlier but had remained independent and self-caring, able to do her own cooking and cleaning. In January 1999, she

started to experience some decline in her memory. Mrs Devine had a history of moderate chronic renal failure and in April the possibility of her having myeloma was considered.

Records confirm that Mrs Devine had an IgA lambda paraprotein, but no Bence-Jones proteins, and nephrotic syndrome. (Paraproteins and Bence-Jones proteins are found in multiple myeloma.) On 15 April, Dr Bob Logan, a consultant geriatrician, referred her to a haematologist to investigate whether she had myeloma. The referral letter stated: *"I would be very grateful for your help in managing this charming 87-year-old lady who is moderately frail, but is very bright mentally."*

A skeletal survey was carried out. Myeloma was not diagnosed but an IgA paraprotein was present.

On 20 July 1999, Mrs Devine was seen by Dr Lennon in Dr Stevens' outpatient clinic. Dr Stevens was a consultant renal physician. Dr Lennon recorded:

> "She remains well on her current treatment with no new problems … her blood test show that her creatinine is slowly worsening and was 192 on the test sample taken. Her albumin is also low at 22. On examination she had oedema to above the knee plus a small sacral pad which may have been from waiting in the waiting room. JVP not raised, heart sounds normal, chest was clear. My impression is that she is stable and weight loss is probably secondary to increased fluid loss with her Frumil … there is no therapeutic intervention which we may undertake at this point."

On 7 September, Dr Stevens saw Mrs Devine in outpatients. She recorded:

> "Problems: Chronic renal failure with small kidneys; nephrotic (syndrome); IgA lambda paraprotein. Mrs Devine's oedema is marked up to her knees. Unfortunately, she has no record of her drugs with her so I was unable to change the dose of diuretics. I think her oedema would benefit from an increase. Blood pressure today was well controlled at 130/70 … Her creatinine is showing gradual rise and in July it was up to 192."

Mrs Devine's creatinine value was 203.

On 9 October, Mrs Devine was admitted to Queen Alexandra Hospital. In the days before admission she had become confused and aggressive and had been found wandering. The referral letter states: *"Confused for 2 days, aggressive and wandering. No history of SDAT [senile dementia of Alzheimer type]."* Mrs Devine was treated with antibiotics for a urinary tract infection (UTI) and was referred to the Mental Health Team.

On 15 October, Dr Taylor, a clinical assistant in old age psychiatry, saw Mrs Devine on the ward at Queen Alexandra Hospital and recorded:

> "I understand that she was admitted on 9.10.99 with an episode of acute confusion. Her daughter says that she did not know who she was, did not know where she was, wandering and aggressive. On the ward apparently she remained acutely confused, trying to get out of windows and possibly hallucinating, although I understand that her behaviour has settled. She remains confused and disorientated but is no longer aggressive or difficult in her behaviour, and is now sleeping better … Up until January of this year [Mrs Devine] was able to look after herself, doing all her cooking and cleaning, but since January the family have noticed a decline in her memory. She has stopped being able to cook and has required somebody to look after her. This seems to have come on since her diagnosis with multiple myeloma back in January."

The letter noted that Mrs Devine's daughter was unable to continue to care for her mother at this time and continued:

> "Past medical history:… Multiple myeloma and hyperthyroidism … There is no known psychiatric history. Current medication: Thyroxine 100mcg daily, Frusemide 80mgs daily, Amiloride 5mgs daily and Cefaclor 37.5mgs bd for presumed UTI, which was thought to be the reason for her coming in to hospital. The staff tell me that she is mobile, she is able to wash with prompting, she takes herself to the toilet and is independent in her self-care, but does tend to get lost around the ward and needs prompting. She is now sleeping well and settled during the day, but apparently is quite aggressive towards her daughter, and feels that her daughter has put her away. On examination of her mental state: She was in her nightie. She was very calm and co-operative and quite friendly. Her speech was normal in rate and form and [Mrs Devine] denied feeling unhappy. At the time of seeing her there was no evidence of delusions or hallucinations, but she did think her daughter was on holiday, and she had no idea where she was. She herself feels that she has no problems with her memory, but unfortunately she only scored 9/30 on an MMSE [mini mental state examination]. She is very deaf and may not have heard or understood a lot of what I was saying because of this. I am sure this lady has a diagnosis of dementia, how much this is related to her underlying myeloma I do not know, but the situation seems to be that she cannot return home, and would therefore recommend referring her to Social Services for Residential Care, and recommend that she needs 24-hour care with a Home that has experience in dealing with memory problems, but currently she does not need an EMI [elderly mentally infirm] Home, as her behaviour is settled. However, if her behaviour deteriorates whilst in hospital, let us know and we will consider transferring her to Mulberry for further assessment."

On the same day, Dr Taylor wrote to social services and expressed the view that Mrs Devine was *"suitable for experienced residential care".*

On 18 October, a CT scan of Mrs Devine's brain was carried out. The scan report noted: *"Involutional and Ischaemic changes present."*

On 20 October, Mrs Devine was assessed by Dr Jayawardena, a consultant geriatrician on the ward at Queen Alexandra Hospital. He reported:

> "I visited Mrs Devine, an 88 year old Lady, who suffers from moderate chronic renal failure and was admitted with a history of a urinary tract infection. She has recovered from the above problems. She is quite alert, can stand and rather unsteady on walking. I found her chest clear, no evidence of cardiac failure and I find her suitable for a rehabilitation programme. The patient requests to be transferred to Gosport War Memorial Hospital and I will make arrangements for this."

The transfer letter stated:

> "… [patient] admitted with [inconclusive] confusion ?UTI. Originally was at times aggressive but this has resolved now she knows us better. Due to her CRF [chronic renal failure] we treated her for a UTI and apart from needing guidance and reassurance is self-caring. Her social circumstances have changed drastically and she needs temporary placement with you until a permanent place is [found]."

By this time, Mrs Devine had been diagnosed with dementia. However, her condition had improved, her behaviour was settled and she was ready for discharge from Queen Alexandra Hospital. At this stage she was described as alert and able to stand, although she was unsteady on her feet. Her chest was clear, there was no evidence of cardiac failure and she was deemed suitable for a rehabilitation programme. Although she was fit for discharge, Mrs Devine could not return home at this time because of an illness in the family. The hospital had arranged for her to be transferred to a care home but her daughter was very concerned about this placement and insisted that she be transferred to Gosport War Memorial Hospital.

On 21 October, Mrs Devine was transferred to Dryad Ward at Gosport War Memorial Hospital under the care of Dr Richard Ian Reid, pending her return home or discharge to an appropriate residential home. The admission record confirms her diagnosis to be chronic renal failure.

On admission, Mrs Devine was assessed by Dr Jane Barton, who noted:

> "… transfer to Dryad Ward continuing care HPC [history of present condition] acute confusion admitted to Mulberry-QA-Dryad (Mulberry details not reviewed). PMH [past medical history] Dementia, Myeloma, Hypothyroidism. Bartel,- transfers with one, so far continent, needs some help with ADL. MMSE 9/30. Bartel - (8/30) Plan: - get to know, assess rehab. potential, probably for rest home in due course."

Panel comments – Box 1

- The Panel has not seen any document to confirm that Mrs Devine went to Mulberry Ward before being transferred to Dryad Ward.

The nursing notes record:

> "… admitted this PM from F3 QAH. Was admitted due to increasing confusion and aggression. The aggression has now resolved. Still seems confused at times. Has [chronic renal failure] needs minimal assistance with ADLs. A very pleasant lady. Her appetite on the whole is not good and can be a little unsteady on her feet."

Dr Barton then prescribed morphine oral solution 2.5–5 ml (5–10 mg morphine) four hourly.

Panel comments – Box 2

- There are no medical records to confirm on what basis Dr Barton prescribed morphine oral solution.
- The Panel has not seen any record to confirm that this drug was clinically indicated at any time.

In relation to the morphine oral solution prescription, Dr Barton stated in a police interview in April 2006: *"I was concerned that a low dose of pain relieving medication should be available for [Mrs Devine] in case she experienced distress and discomfort and a Doctor was not available to write up a prescription for her."*

During the 2009 GMC Fitness to Practise (FtP) hearing, Dr Barton stated:

> "At some time in the future, during her admission I imagine that she might suffer from pain from her chronic renal problem or pain and distress at the end stages of her dementia, and I wanted to have it there on the drug chart should we need it in the future. I was not anticipating using the drug at that time … We did use it in the

> confusion that we saw in end-stage dementia, because it was very difficult to find something to make somebody comfortable at that end of their life, even in terminal dementia … Confusion, mental distress, agitation, fear: all a spectrum of emotions with or without an element of psychological pain behind them, very difficult to distinguish, very difficult to treat, very difficult to look after. Sometimes these people deserved a small dose of opiate."

Panel comments – Box 3

- The Panel notes that Dr Barton did not record her rationale in the clinical notes at the time this decision was made.
- The Panel notes that Dr Barton did not prescribe simple analgesia.
- Dr Barton did not record the explanation for prescribing morphine oral solution she provided to the police in Mrs Devine's clinical notes at the time of her assessment.
- The Panel has not seen any record of administration of morphine oral solution.

On 25 October 1999, Dr Reid assessed Mrs Devine and noted that she was *"Mobile unaided, washes with supervision, dresses self, continent, mildly confused".*

On 1 November, Dr Reid assessed Mrs Devine again and noted that she was *"physically independent but needs supervision with washing and dressing, help with bathing. Continent. Quite confused and disorientated e.g. undressing during the day is unlikely to get much social support at home."* Dr Reid prescribed amiloride.

On 10 November, Mrs Devine was noted to be confused and wandering. The following day Dr Barton prescribed temazepam, trimethroprim and thioridazine.

In relation to the thioridazine, during the 2009 FtP hearing Dr Barton stated:

> "… because we thought clinically she had a urinary tract infection at that time. Thioridazine is a major tranquiliser. The wandering around the ward became quite difficult to manage on an open geriatric ward quite invasive for the other patients and difficult for the staff and that was an attempt to keep her behaviour more in keeping with the rest of the ward. Not a chemical cosh in any way, but just to make her a bit less restless and agitated."

By 11 November, the plan was to arrange for Mrs Devine to visit her home twice weekly to see her family and to assess if she would function better in her own home.

By 15 November, when Dr Reid assessed her, Mrs Devine had become restless and aggressive. Dr Reid noted:

> "… very aggressive at times, has needed thioridazine. On treatment for UTI; MSU sent, blood and protein in urine. Examined by Dr Reid: Pulse 100, regular. Temperature 36.4, JVP not raised, hepato-jugular reflex +ve. Heart sounds- nil added. Oedema +++ to thighs. Chest clear. Bowels regular- PR empty 13.11.99. but good bowel action since. (MSU* -no growth). Ask Dr Lusznat to see."

The nursing care plan records confirm that: between 21 October and 13 November Mrs Devine regularly opened her bowels; between 21 October and 20 November she slept well, except for 10 November when she wandered during the night, and 15 November when she got up to use

the toilet and was *"disruptive before settling"*; and between 21 October and 18 November she bathed and washed daily with assistance.

Panel comments – Box 4

- There are no bowel movement notes after 13 November.
- There are no personal hygiene notes after 18 November.

On 18 November, a locum staff psychiatrist from the Department of Elderly Mental Health assessed Mrs Devine and noted:

> "This lady has deteriorated and has become much more restless and aggressive again. She's refusing medication and not eating well. She does not seem to be depressed and her physical condition is stable. I'll arrange for her to go to Mulberry."

Mrs Devine's physical condition was noted to be stable and plans were made to transfer her to Mulberry Ward. Dr Barton prescribed a 25 microgram fentanyl patch every three days.

Panel comments – Box 5

- The Panel has not seen any record to confirm that fentanyl was clinically indicated.

In relation to the fentanyl prescription, Dr Barton stated during an interview with Hampshire Constabulary in November 2004:

> "Having received the blood test results, it became apparent that transfer would not be appropriate, even if a bed did become available, and that her medical condition was deteriorating significantly, accompanied by marked restlessness and agitation. After discussion amongst the team who were concerned about her obvious discomfort, and given the fact she was refusing to take medication, I decided to commence a Fentanyl 25 mcg patch on the skin. This was in an attempt to calm her, to make her more comfortable, and to enable nursing care. [Mrs Devine] was not eating or drinking well by this stage. I did not feel that a subcutaneous infusion would be helpful at that point as she was likely simply to remove it."

During the 2009 FtP hearing, Dr Barton stated:

> "She was aggressive, wandering, moving other people's clothes, refusing medication, so anything that I was going to give her to make her more comfortable and peaceful would not be an oral agent because she would refuse it or spit it out. I was looking at a parenteral preparation to ease these symptoms. In my mind at that point she was becoming end-stage dementia which are the most difficult patients to look after and make comfortable because of all those things you talked about: What is the pain? Where is the pain? superimposed on her deteriorating renal function. So she had two major comorbidities, she was becoming very unwell, and I thought that a transdermal patch at that point in time was a kinder way of controlling her symptoms. Subcutaneous infusion would have been very difficult to administer in somebody who was that restless and aggressive … I think I probably would have gone for the [morphine oral solution] and carried on with a higher dose of the thioridazine, but that was becoming impossible to give because she did not want to take the tablets."

In relation to the presence of pain, Dr Barton stated:

> "Not physical pain but not happy, not comfortable, not easy to look after. Restless, wandering, climbing into other people's beds: not a picture of a lady who was at peace with herself, although there were no physical signs of pain."

Panel comments – Box 6

- The Panel notes that Dr Barton did not record the rationale provided to the police and the FtP hearing in the clinical notes at the time this decision was made.
- The Panel has not seen any record of Mrs Devine experiencing pain.
- The Panel has not seen any fluid charts in the medical records. In the case of a patient with renal failure, fluid management is essential.
- The Panel has not seen any record to confirm that there were adequate attempts to rehydrate Mrs Devine.
- The Panel found no document in the medical records to confirm Dr Barton's rationale for prescribing fentanyl. It is clear from later records that the fentanyl patch was administered; however, this is not recorded on the drug chart. The Panel observes that the use of fentanyl might have compounded the deterioration in Mrs Devine's mental state.

On 19 November, Dr Barton assessed Mrs Devine and noted that there had been:

> "… [a] marked deterioration overnight, confused, aggressive. Creatinine 360. Fentanyl patch commenced yesterday; today further deterioration in general condition needs subcutaneous analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable; I'm happy for nursing staff to confirm death."

Dr Barton prescribed a subcutaneous infusion of diamorphine 40–80 mg and midazolam 20–80 mg over 24 hours.

The nursing notes record:

> "… marked deterioration over the last 24 hours. Extremely aggressive this am refusing all help from all staff. chlorpromazine 50mg given [intra muscularly] at 08.30. Taken two staff to special. Syringe driver commenced at 09.25 Diamorphine 40mg and Midazolam 40mg. Fentanyl Patch removed."

Panel comments – Box 7

- The Panel has not seen any record to confirm that diamorphine and midazolam were clinically indicated at this time. In addition, the Panel has not seen any document in the medical records to confirm the rationale for the high starting doses.

In relation to the diamorphine and midazolam prescription, Dr Barton stated in her police interview:

> "… on the morning of 19th November I found [Mrs Devine] in an extremely aggressive state, hanging onto the bars in the main corridor of the ward. She was clearly very agitated, anxious, and distressed. She would not allow anyone to approach her or administer any of her usual medication; In due course we were able to administer 50mg of Chlorpromazine intramuscularly. This took some time to be effective, but in due course we were able to get her back into her own bed. This major tranquilliser

had made her quite drowsy and we made the decision to discontinue the transdermal Fentanyl which I knew would have taken about 22 hours to reach steady state drug levels, and to opt instead for subcutaneous analgesia. As [Mrs Devine] had already received opiates in the form of the Fentanyl, and had been resistant to this to a degree, I prescribed 40mgs of Diamorphine, to be administered via syringe driver over 24 hours, together with 40mgs of Midazolam. This medication was prescribed at 9.25 a.m. (9:25) and was administered with the sole intention of relieving [Mrs Devine's] significant distress, anxiety and agitation, which were clearly very upsetting for her. I also prescribed Hyoscine to be given when required, to dry any chest secretions, but in fact it did not prove necessary to administer this. At this point it was clear that [Mrs Devine's] renal function had deteriorated markedly, superimposed on her dementia, and she was now dying. The Fentanyl patch was removed a little later."

During the 2009 FtP hearing, Dr Barton stated:

"[Mrs Devine] was halfway down the main corridor of the ward, hanging on to the bars and it was impossible for any of them to move her … [chlorpromazine was a] major tranquiliser, sedative. She was not safe standing there in the corridor. She needed to be in her bed, and it was going to take a major tranquiliser to peel her off the wall and get her into her own room … I suspected, her renal function had deteriorated quite quickly and quite markedly, and was probably contributing to the end stage dementia state that she was in. I did not think that it was related to the fentanyl. I thought that the fentanyl was not doing anything to make it better … [Although no active sign of pain] I wanted the midazolam. I needed the sedation and the anxiolytic properties of the midazolam in order to calm her down once the chlorpromazine wore off, and I was minded to continue an equivalent amount of diamorphine to replace the fentanyl dose that she had been having … I understood that the equivalence of the fentanyl was 90 mg of morphine in 24 hours, so using my conversion factor which was to halve it, the equivalent in diamorphine in 24 hours would be 40. I also knew that when you took the fentanyl patch off the level of fentanyl in the blood stream slowly reduced."

On 19 November, the 'Contact Records' found in the hospital records note: *"social services informed to close the case. Mulberry also informed."*

Panel comments – Box 8

- The Panel notes that Dr Barton did not record the rationale provided to the police and the FtP hearing in the clinical notes at the time she made the decision to prescribe diamorphine and midazolam.
- The Panel notes that Mrs Devine was an opioid-naïve patient with renal failure; however, she was commenced on a high dose of diamorphine.
- The Panel also notes that when diamorphine was administered, fentanyl would still have been pharmacologically active in Mrs Devine's system despite the patch having been removed.
- There are no clinical records to confirm on what basis Dr Barton prescribed diamorphine.
- There are no clinical records to confirm the rationale for the dose of diamorphine. There are no records to confirm that diamorphine was clinically indicated.

On 20 and 21 November, the syringe driver was recharged at 07:35 and 07:15 respectively.
On 21 November, Mrs Devine died on Dryad Ward at Gosport War Memorial Hospital at 20:30.

Panel comments – Box 9

- The records confirm that Dr Logan referred Mrs Devine to a haematologist because he suspected that she might have myeloma. Although myeloma was not detected in the skeletal survey and was not diagnosed, this appears not to have been picked up by a number of clinicians, including the Mental Health Team who variously and wrongly referred to myeloma as part of Mrs Devine's medical history. During the FtP hearing in 2009, Dr Barton confirmed that *"the diagnosis was not, as it turned out, correct … I had taken it from the transfer letter … so it was not myeloma, it was a form of paraproteinemia".*
- The acute confusion which led to Mrs Devine's admission on 9 October, and its subsequent improvement, would be compatible with a diagnosis of delirium. The records indicate that Mrs Devine also had mild dementia.
- The Panel notes from the records that Mrs Devine was tested for a UTI and the result was reported as negative.
- The Panel notes that there are no records to indicate that at any stage when prescribing or administering morphine oral solution, fentanyl or diamorphine, Mrs Devine's severe renal impairment was considered.
- The Panel notes that Mrs Devine's renal function had deteriorated but had not been managed. The records do not contain any recent fluid balance chart or any urine output records.
- At the time of Mrs Devine's admission, guidance from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) (see Bibliography) emphasised the requirement for nurses to work in an open and cooperative manner with patients and their families. In this regard, the Panel has seen no documents in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Mrs Devine's family.
- At the time of Mrs Devine's admission, accountability was an integral part of nursing practice. Nurses were accountable for their actions, and inactions, at all times. The relevant nursing professional codes of conduct and standards required nurses to scrutinise a prescription; question any ambiguity in the prescription; where they believed it necessary, refuse to administer a prescription; and report to an appropriate person or authority any circumstances which could jeopardise the standards of practice or any concern about health services within their employing Health Authority or Trust. The codes and guidance made it clear that to silently tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and contrary to personal professional accountability. The Panel has not seen any document to confirm that nurses treating Mrs Devine challenged the proactive prescription of morphine oral solution, the prescription of fentanyl or the wide dose range in the prescription of diamorphine and midazolam. The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines to scrutinise the doses; nor did they question any of the consultants, doctors or the pharmacist at Gosport War Memorial Hospital in respect of the prescription and doses.
- The Panel notes that the relevant nursing codes of conduct and standards provided that, when administering or overseeing the administration of drugs, nurses should be able to justify and be accountable for any actions taken.
- The Panel has not seen any nursing document in the clinical records to show the reason or rationale for the decision to commence and continue the use of fentanyl, diamorphine and midazolam.
- The Panel has not seen any nursing document in the clinical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of fentanyl, diamorphine and midazolam.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of fentanyl, diamorphine and midazolam.
- At the time of Mrs Devine's admission, the UKCC guidance required nurses to carry out a comprehensive assessment of the patient's nursing requirements, and devise, implement and keep under review care plans. The UKCC guidance also required nurses to create and maintain medical records in order to provide accurate, current, comprehensive and concise information concerning the condition and care of the patient. Such records would include: details of observations, problems, evidence of care required, action taken, intervention by practitioners, patient responses, factors that appeared to affect the patient, the chronology of events, and reasons for any decision. These records would provide a baseline against which improvement or deterioration could be judged. Among other

elements of care, *"Through their role in drug administration nurses are in an ideal position to monitor the drugs progress, reporting responses and side effects".* In this regard, the Panel found a lack of detail in Mrs Devine's daily nursing notes. The care plans seen by the Panel were scanty, were not personalised to the patient's needs and contained missing entries for entire days. For example, between 21 October and 20 November, the 'Sleep' care plan contained entries on ten days only. Between 21 October and 13 November, the 'Bowel Movement' care plan contained seven entries only. There was nothing that took account of Mrs Devine's cognitive impairment, capabilities, likes, dislikes and preferences. The Panel found no pain charts or pain management plans in Mrs Devine's clinical records. It is not clear to the Panel how Mrs Devine's anticipated pain and the effectiveness of any analgesia was to be adequately monitored. The Panel has found no document which confirms that any assessment of Mrs Devine's cognitive impairment was carried out or was the subject of a care plan.

- The Panel has not seen any fluid charts or nutrition plan among Mrs Devine's clinical records. Fluid and nutritional intake was an important part of the clinical picture. Fentanyl, diamorphine and midazolam could impair the ability to eat and drink.
- In addition to its intended effects, morphine might also have a number of side effects on a patient, including agitation and respiratory depression. The Panel has not seen any document in the clinical records to show that the nurses treating Mrs Devine understood or took into account these possible side effects of morphine when noting Mrs Devine's condition. In this regard, the relevant nursing codes of conduct and standards required nurses to take every reasonable opportunity to maintain and improve knowledge and competence, including understanding the substances used when treating a patient.

In a police statement dated November 2004, Dr Barton said:

> "As you should be aware, following [Mrs Devine's] death, her care was considered carefully by an Independent Review Panel [IRP]. The [IRP] was assisted in its consideration by specialist clinical assessors, including an assessor who specialised in elderly medicine. The Panel's report contained the following observations 'The drugs given to Mrs Devine were not contradicted either by using in combinations stated or with her medical condition. On the morning of Friday 19th November 1999, [Mrs Devine] was wandering, agitated, acutely confused, disorientated and frightened. In a frail elderly person this is a very serious medical condition and may be as dangerous as a heart attack but it does not form part of the public perception of a serious or life threatening illness. For this reason she clearly required a large dose of strong medication, as she was a danger to both herself and people around her. The fact that she was still responding to her daughter … by squeezing her hand at the sound of her voice, that day and the next day, suggested that the medications she was given was reasonable and was in the best interest of the patient to keep her comfortable. In conclusion the [IRP] found that the drugs, doses and devices used to make [Mrs Devine] comfortable on the 19 November were an appropriate and necessary response to an urgent medical situation' Given these findings I am at a loss to understand why you should consider there are any reasonable grounds whatsoever for suspecting that I might have committed any criminal offence."

In fact, after Mrs Devine's daughter had received the conclusions of the Independent Panel Review and remained dissatisfied, a member of the Independent Panel produced a further report, which contained the above conclusion. This was not the report of the entire Independent Panel.

Panel comments – Box 10

- This is an extraordinary conclusion, explicitly condoning the use of large doses of diamorphine simply to control symptoms of confusion and agitation, contrary to all relevant guidance.

Case Study – Gladys Richards

Summary of hospital admission

- In 1998, Gladys Richards was aged 91 and was resident in a nursing home.
- On 29 July, she fell and fractured her right neck of femur. She was admitted to the Royal Hospital Haslar ('Haslar Hospital'), where she underwent a right cemented hemiarthroplasty (partial hip replacement).
- On 11 August, she was admitted to Gosport War Memorial Hospital for rehabilitation.
- On 13 August, she fell at Gosport War Memorial Hospital and dislocated her right hip.
- On 14 August, she was transferred to Haslar Hospital where the dislocation was treated.
- On 17 August, she returned to Gosport War Memorial Hospital.
- On 21 August, Mrs Richards died.

Background, care and treatment

On 4 February 1998, Mrs Richards was assessed by Dr Victoria Banks, a psychiatrist specialising in old age. Dr Banks confirmed that Mrs Richards was *"cognitively … obviously severely impaired".* However, she was not found to be depressed. Dr Banks's view was that Mrs Richards had *"severe dementia with end stage illness"*. She prescribed a regimen of haloperidol, trazodone and lavender oil, with the possibility of utilising other drugs in the future. By May 1998, Mrs Richards was described by staff at the nursing home as *"withdrawn and anxious at times"* but as being settled most of the time due to her new drug regimen. Mrs Richards wore pads for incontinence, required help with washing and dressing and also needed encouragement and help to eat. She would usually sleep through the night but would get up and wander at times. Mrs Richards' daughters and granddaughter were heavily involved in her day-to-day care and would visit her at the nursing home daily. The records indicate that Mrs Richards had hearing difficulties and had been awaiting new hearing aids. Records confirm that by the time of her admission to Haslar Hospital, Mrs Richards had a six-month history of falls, the last fall resulting in her fractured neck of femur on 29 July.

On 29 July, Mrs Richards was admitted to Haslar Hospital where she underwent a right cemented hemiarthroplasty (partial hip replacement).

On 5 August, Dr Richard Ian Reid assessed Mrs Richards at Haslar Hospital. He noted:

> "[Mrs Richards] has been confused for some years but was mobile in her nursing home until around Christmas 1997 when she sustained a fall. She started to become increasingly noisy. She was seen by Dr V Banks who presumably felt that she was depressed as well as suffering from a dementing illness. She has been on treatment with haloperidol and trazodone. According to her daughters she has been 'knocked-off' by this medication … and has not spoken to them for six to seven months. Her mobility has also deteriorated during that time and when unsupervised she has a tendency to get up and fall … I believe that she is usually continent of urine but has occasional episodes of faecel incontinence. Since her operation she has

> been catheterized … [she] has been noisy at times … she has been continued on Haloperidol, her Trazodone has been omitted. According to her daughters … she has been much brighter mentally and has been speaking to them at times."

Dr Reid also noted:

> "Mrs Richards was confused and unable to give any coherent history … She was pleasantly cooperative [and] was able to move her left leg quite freely and although not able to actively lift her extended right leg from the bed she appeared have a little discomfort on passive movement of the right hip … [and] has been sitting out in a chair … despite her dementia she should be given the opportunity to try to re-mobilise."

Dr Reid confirmed that he would arrange Mrs Richards' transfer to Gosport War Memorial Hospital and noted that her daughters were unhappy with the care she had received at the nursing home.

On 11 August, Mrs Richards was discharged from Haslar Hospital and her recommended drug treatment was *"Haloperidol Suspension, Lactulose and Co-codamol"*, all of which were to be taken orally. The discharge letter from Haslar Hospital to Gosport War Memorial Hospital stated: *"[Mrs Richards] had a right cemented semi-arthroplasty and she is not fully weight bearing. Walking with the aid of two nurses and a Zimmer."* The letter advised that Mrs Richards:

> "… needed total care with washing and dressing, eating and drinking … daughters are extremely devoted and like to come in and come in and feed her at meal times … Mrs Richards has a soft diet and enjoys a cup of tea … [is] continent [and] when she becomes fidgety and agitated it means she wants the toilet, occasionally continent at night but usually wakes … Occasionally says recognizable words but not very often."

On admission to Gosport War Memorial Hospital on 11 August, Mrs Richards was assessed by Dr Barton who recorded in the clinical notes: *"transfer to Daedalus Ward for continuing care … impression frail demented lady not obviously in pain please make comfortable. Transfers with hoist, usually continent, needs help with ADL, Bartel 2. I am happy for nursing staff to confirm death."* Dr Barton wrote a prescription for morphine oral solution 2.5–5 ml (5–10 mg morphine) four hourly as required, and diamorphine 20–200 mg, hyoscine 200–800 micrograms and midazolam 20–80 mg to be administered by subcutaneous infusion over 24 hours.

The records confirm that morphine oral solution 10 mg was administered to Mrs Richards on 11 August at 14:15 and 23:45. The drug charts also confirm that haloperidol was administered to Mrs Richards on 11 August at 18:00.

Panel comments – Box 1

- The Panel notes the anticipatory prescribing of morphine oral solution.
- The Panel notes the anticipatory prescribing of diamorphine, hyoscine and midazolam in high and very wide dose ranges.
- The Panel has not found any document in the clinical records to show that morphine oral solution, diamorphine, midazolam and hyoscine were clinically indicated on 11 August.
- The Panel has not found any document in the clinical records to confirm Dr Barton's rationale for prescribing morphine oral solution, diamorphine, midazolam and hyoscine on 11 August.
- It is not clear from the clinical records why, having noted Mrs Richards as *"not obviously in pain"*, Dr Barton prescribed morphine oral solution and diamorphine.

- It was usual in the health service to use *"TLC"* (tender loving care) or *"make comfortable"* as euphemisms for patients who were to be treated palliatively.
- It is not clear from the medical records why Dr Barton requested that Mrs Richards be *"made comfortable"* and why Dr Barton noted that she was *"happy for nursing staff to confirm death"* in circumstances where Dr Reid had decided Mrs Richards should be given the *"opportunity to … re-mobilise"*.

In relation to her note *"happy for nursing staff to confirm death"*, Dr Barton stated during an interview with Hampshire Constabulary in July 2000:

> "[Mrs Richards] was probably near to death, in terms of weeks and months from her dementia before the hip fracture supervened. Given her transfer from nursing home to acute hospital and then to continuing care and the fact that she had recently undergone major surgery; in addition to her general frailty and dementia, I appreciated that there was a possibility that she might die sooner rather than later. This explains my reference at that time to the confirmation of death, if necessary by the nursing staff."

During the GMC Fitness to Practise (FtP) hearing in 2009, Dr Barton stated:

> "That was a routine entry I made into the notes of patients who might at some time in the future die on the ward [so that] … nursing staff … did not have to bring in an out of hours duty doctor to confirm death … it did not signify at that time I felt that she was close to death; it was a fairly routine entry in the notes."

In her police interview, in relation to the prescription of morphine oral solution and diamorphine on 11 August, Dr Barton stated:

> "[Mrs Richards] was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including [morphine oral solution] and Diamorphine."

During the FtP hearing, Dr Barton stated:

> "The snapshot view that I gained of that patient when I examined her on the bed that afternoon was that she was not obviously in pain; but I knew perfectly well that she had just had a transfer from another hospital, she had not long had fairly major surgery and she was very frail anyway. She was going to be very uncomfortable for the first few days and I was minded to make available to the nurses a small dose of oral opiate in order to make her comfortable during that time not to be administered regularly but at their discretion if they felt she needed it."

In relation to the prescription of diamorphine, Dr Barton said:

> "Because I felt that this lady her outlook on the background of her very severe dementia … and the major surgery, that her general outlook was poor. She was quite possibly going to need end of life care sooner rather than later."

Dr Barton went on to state that post-operative analgesia was often inadequate and she would have expected Mrs Richards to still be in pain when she was transferred to Gosport War Memorial Hospital.

Panel comments – Box 2

- The Panel has found no documents in the clinical records to confirm that Mrs Richards was screaming as if in pain on 11 or 12 August.
- Dr Barton did not record any of the above views in Mrs Richards' clinical notes at the time of her admission and, given Dr Reid's view that Mrs Richards should be given the opportunity to remobilise, and Haslar Hospital had prescribed co-codamol only, it is not clear to the Panel why Dr Barton did not discuss her views and prognosis with Mrs Richards' consultant or any members of her family.
- At the time of Mrs Richards' admission, guidance from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) (see Bibliography) emphasised the requirement for nurses to work in an open and cooperative manner with patients and their families. In this regard, the Panel has seen no documents in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Mrs Richards' family.
- At the time of Mrs Richards' admission, accountability was an integral part of nursing practice. Nurses were accountable for their actions, and inactions, at all times. The relevant nursing professional codes of conduct and standards required nurses to scrutinise a prescription; question any ambiguity in the prescription; where they believed it necessary, refuse to administer a prescription; and report to an appropriate person or authority any circumstances which could jeopardise the standards of practice or any concern about health services within their employing Health Authority or Trust. The codes and guidance made it clear that to silently tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and contrary to personal professional accountability. The Panel has not seen any document to confirm that nurses treating Mrs Richards challenged the proactive and wide dose range prescriptions of morphine oral solution, diamorphine and midazolam. The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines to scrutinise the doses; nor did they question any of the consultants, doctors or the pharmacist at Gosport War Memorial Hospital in respect of the prescription and doses.
- The relevant nursing codes of conduct and standards required nurses to be able to justify and be accountable for any actions taken when administering or overseeing the administration of drugs. The Panel notes that the relevant nursing codes of conduct and standards provided that, when administering or overseeing the administration of drugs, nurses should be able to justify and be accountable for any actions taken.
- The Panel has not seen any document in the clinical records to show the reason or rationale for the decision to commence morphine oral solution on 11 and 12 August, or for the choice of a 10 mg starting dose.
- The Panel has not seen any document in the clinical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of morphine oral solution to Mrs Richards or when choosing a 10 mg starting dose, which was the higher dose on the range prescribed by Dr Barton.
- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of morphine oral solution or the choice of starting dose.
- At the time of Mrs Richards' admission, the UKCC guidance required nurses to carry out a comprehensive assessment of the patient's nursing requirements, and devise, implement and keep under review care plans. The UKCC guidance also required nurses to create and maintain medical records in order to provide accurate, current, comprehensive and concise information concerning the condition and care of the patient. Such records would include: details of observations, problems, evidence of care required, action taken, intervention by practitioners, patient responses, factors that appeared to affect the patient, the chronology of events, and reasons for any decision. These records would provide a baseline against which improvement or deterioration could be judged. Among other elements of care, *"Through their role in drug administration nurses are in an ideal position to monitor the drugs progress, reporting responses and side effects".* In this regard, the Panel found a lack of information in Mrs Richards' daily nursing notes. The care plans seen by the

Panel were scanty, were not personalised to the patient's needs and contained missing entries for entire days. For example, the 'Personal Hygiene' care plan appeared to be a typed proforma and stated: *"patient is unable to maintain own personal hygiene … ensure patient is clean or comfortable at a level acceptable to him or her".* There was nothing that took account of Mrs Richards' cognitive impairment, capabilities, likes, dislikes and preferences. The Panel found no pain charts or pain management plans in Mrs Richards' medical records. It is not clear to the Panel how Mrs Richards' pain and the effectiveness of analgesia were adequately monitored. The Panel has found no document to confirm that any assessment of Mrs Richards' cognitive impairment was carried out or was the subject of a care plan.

- The Panel has not seen any fluid charts among Mrs Richards' medical records and the nutrition plan was a proforma which contained entries for 13, 14 and 21 August only. Fluid and nutritional intake was an important part of the clinical picture. Morphine oral solution, diamorphine and midazolam could impair the ability to eat and drink.

On 12 August 1998, Dr Barton wrote further prescriptions for morphine oral solution 2.5–5 ml (5–10 mg morphine) four hourly, and 5 ml (10 mg morphine) in the evening as required. The records confirm that morphine oral solution 10 mg was administered to Mrs Richards at 06:15. Nursing notes for the evening of 12 August recorded, at 18:00, *"patient drowsy"* and, at 23:00, that Mrs Richards was having difficulty settling at night and was agitated, shouting and crying but that *"she did not seem to be in pain".* There are no clinical notes on 12 August.

Panel comments – Box 3

- The Panel has not found any document in the medical records to show that morphine oral solution was clinically indicated on 12 August.
- The Panel notes that following the administration of three doses of morphine oral solution 10 mg on 11 and 12 August, Mrs Richards was noted to be *"drowsy"*.

On 13 August, the nursing notes record:

> "… found on the floor at 13.30 hours checked for injury none apparent at time hoisted into safer chair. At 19.30 pain rt hip internally rotated. Dr Brigg contacted advised Xray AM and analgesia during the night. Inappropriate to transfer for Xray this PM. Daughter informed."

The drug chart and nursing notes confirm that Mrs Richards was given morphine oral solution at 20:50 and that she *"slept well"*. There are no clinical notes on 13 August.

On 14 August, the nursing notes record *"some pain in rt leg?/hip this am"* and that Mrs Richards ate porridge*.* Dr Barton noted in the clinical records:

> "… sedation/pain relief has been a problem screaming not controlled by Haloperidol … very sensitive to [morphine oral solution]. Fell out of chair last night Right hip shortened and internally rotated daughter aware and not happy please X-ray. Is this lady well enough for another surgical procedure?"

The drug chart confirms that morphine oral solution 5 ml (10 mg) was administered to Mrs Richards at 11:50.

Dr Barton saw Mrs Richards again later that day after the X-ray and contacted Surgeon Commander Spalding at Haslar Hospital. The note records that she relayed Mrs Richards' history of a dislocated hip, sent him Mrs Richards' X-rays and informed him that Mrs Richards had been given morphine oral solution at midday. Later that day, the nursing notes record

that Mrs Richards' hip was dislocated and she was to be transferred to Haslar Hospital *"for reduction under sedation"*.

In the police interview in July 2000, Dr Barton stated: *"Although I was concerned, given Mrs Richards' overall condition and her frailty that she might not be well enough for another surgical procedure, I felt that this clearly would be a matter for assessment by the clinicians at Haslar."*

On the same day, Nurse Philip Beed wrote to Haslar Hospital. He confirmed Mrs Richards' transfer to the accident and emergency department for a reduction of her dislocated hip and that there had been no change in her treatment since her admission to Gosport War Memorial Hospital on 11 August, *"except addition of [morphine oral solution]"*. He confirmed that 10 mg of morphine oral solution had been given to Mrs Richards at 11:50 and that Gosport War Memorial Hospital would be happy to take Mrs Richards back after the reduction.

On 17 August, Mrs Richards was discharged from Haslar Hospital and transferred back to Gosport War Memorial Hospital. The discharge letter confirmed that Mrs Richards *"underwent a closed reduction under IV sedation. The reduction was uneventful. However she was rather unresponsive following the sedation then gradually become more responsive but was unable to pass urine."* Mrs Richards was given 2 mg of midazolam as sedation for the reduction procedure. The letter confirms that Mrs Richards had been catheterised and had been given a canvas knee-immobilising splint *"to discourage any further dislocation"*. The splint was required to stay in place for four weeks. The letter made it clear that Mrs Richards could *"mobilise fully weight bearing"* and that when she was in bed it was advisable to encourage abduction by use of pillows or an abduction wedge.

The nursing notes record that, at 11:48, Mrs Richards had returned to Gosport War Memorial Hospital and was very distressed and appeared to be in pain. The notes record that Mrs Richards had been transferred by the ambulance crew on a sheet and not canvas. The nursing notes record the advice from Haslar Hospital that abduction in bed should be encouraged and specifically the advice from Haslar Hospital that there would be *"no follow up unless complication".* At 13:05 the Gosport War Memorial Hospital records further note that Mrs Richards was in pain and distress and that *"2.5 mg in 5 ml"* of morphine oral solution was given to her, although the drug charts record the dose given as 2.5 ml (5 mg morphine). The notes record that Mrs Richards' daughter had informed staff that the surgeon had said *"must not be left in pain if dislocation occurs again".* The note records that Dr Barton was contacted and she ordered that an X-ray be carried out. The nursing record ends: *"PM Hip Xrayed … no dislocation seen … for pain control overnight and review by Dr Barton."*

Mrs Richards was given three 2.5 ml doses of morphine oral solution (5 mg morphine) and one 5 ml dose of morphine oral solution (10 mg morphine) between 13:00 and 20:30 on 17 August.

Dr Barton's untimed clinical note records: *"readmission … from RHH. Closed reduction under IV sedation. Remained unresponsive for some hours. Now appears peaceful. Please continue Haloperidol. Only give [morphine oral solution] if in severe pain."*

In her police interview in July 2000, Dr Barton stated:

> "At the time of her arrival back on the ward Mrs Richards appeared peaceful and not in severe pain. This was however an initial judgement made on an assessment shortly after her arrival on the ward. I was concerned that she should have opiates only if her pain became a problem, and I altered her drug chart accordingly. I was not aware

> at that time that she had been having intravenous morphine at [Haslar Hospital] until shortly before her transfer. This would have explained why at this time she appeared to be peaceful and not in pain."

Panel comments – Box 4

- It is not clear to the Panel at what time Dr Barton first saw Mrs Richards on 17 August. However, it is clear from the nursing notes that Mrs Richards arrived on the ward around 11:50 and was in distress and pain and therefore was not peaceful on her arrival at Gosport War Memorial Hospital. It is also clear that Mrs Richards was noted to be in pain and distress again at 13:05 when a dose of morphine oral solution was administered to her. During the FtP hearing Dr Barton confirmed that she must have seen Mrs Richards after she had received this dose of morphine oral solution, that Mrs Richards had not received intravenous morphine at Haslar Hospital, and that this was an error in her police statement.

On 18 August, Mrs Richards was given two 5 ml doses of morphine oral solution (10 mg morphine) between 02:30 and 04:30. Dr Barton later noted, *"still in great pain, nursing a problem I suggest s.c. [subcutaneous] diamorphine / haloperidol / midazolam … please make comfortable".* The drug charts confirm that Dr Barton wrote another prescription for diamorphine 40–200 mg subcutaneously over 24 hours. In the later police interview, Dr Barton stated that when she examined Mrs Richards there was a lot of swelling and tenderness around the area of the prosthesis. It was her assessment that Mrs Richards had *"developed a haematoma or a large collection of bruising around the area where the dislocated prosthesis had been lying whilst dislocated"* and that this was in all probability the cause of the pain. Dr Barton confirmed her view that *"this complication would not have been amenable to any surgical intervention"* and that transfer to Haslar Hospital was not in Mrs Richards' best interests.

During the FtP hearing, Dr Barton stated:

> "[Mrs Richards] was not well enough to return to the acute orthopaedic ward. We knew she had a large haematoma, or bruise, around where the dislocation had been put back. I knew that nothing surgically could have been done for this condition and that it would just have to be allowed to heal in its own time, if her condition permitted and she remained well enough … I did not feel that a transfer back to an acute unit at that point was in [Mrs Richards'] interests. She probably would not have even survived the journey back, so we had to continue on our route of palliative care, becoming terminal care."

Panel comments – Box 5

- The Panel notes that Dr Barton did not consult the clinicians at Haslar Hospital about Mrs Richards' haematoma, treatment and transfer, having previously decided that consultation was necessary.
- The Haslar Hospital transfer letter stated *"no follow up unless complication".* It is not clear to the Panel why Dr Barton did not consult the clinicians at Haslar Hospital in light of the apparent complication.
- It is not clear to the Panel why Dr Barton did not investigate the presence and the nature of any haematoma.
- It is not clear to the Panel on what basis Dr Barton determined that any haematoma was not amenable to surgical intervention or any other form of treatment.
- It is not clear to the Panel why Dr Barton did not record this diagnosis and view in her clinical notes at the time she assessed Mrs Richards. There are also no nursing notes to reflect this diagnosis.

On 18 August, the nursing notes state: *"reviewed by Dr Barton, for pain control via syringe driver".* The records confirm that at 11:45 the administration of diamorphine 40 mg, haloperidol 5 mg and midazolam 20 mg was commenced by syringe driver.

In the later police interview, Dr Barton confirmed her rationale for prescribing the subcutaneous administration of diamorphine as follows:

> "I explained that it was the most appropriate drug as their mother was not eating or drinking or able to swallow, subcutaneous infusion … was the best way to control her pain … this drug, the dose used and this mode of administration are standard procedures for patients who are in great pain but who cannot take medicines by mouth."

Dr Barton went on to explain that Mrs Richards had not responded to 45 mg of morphine oral solution over the previous 24 hours, so it was necessary to introduce the use of diamorphine.

During the FtP hearing, Dr Barton stated:

> "I calculated the number of doses of [morphine oral solution] she had had in the preceding 24 hours and the conversion for that should have been approximately 20mg, but her pain was not controlled so I was minded to increase it, hence 40mg and agreed that in effect, if the figure with regard to the [morphine oral solution] was a total of 45 in the previous 24 hours."

Dr Barton stated that this was an *"appropriate starting dose for [Mrs Richards'] symptoms".*

Panel comments – Box 6

- The Panel has found no document in the medical records to confirm Dr Barton's rationale for increasing the dose range of diamorphine to 40–200 mg.
- The Panel notes that the administration of diamorphine 40 mg over 24 hours by syringe driver in a patient who had received 45 mg of morphine oral solution in the previous 24 hours constitutes more than a doubling of the effective dose of morphine. The Panel can find no justification in the clinical records for this increase in dosage.
- As noted above, the Panel has not found any pain management records for Mrs Richards; accordingly, it is not clear on what basis Mrs Richards' response to analgesia was being assessed and determined.
- The Panel has not found any document in the clinical records to show that on 18 August the nurses scrutinised or questioned Dr Barton's prescription of diamorphine and midazolam or refused to administer these drugs.
- It is also not clear from the records on what basis Dr Barton had concluded that Mrs Richards was not eating, drinking or able to swallow. The Panel has not found any fluid charts in the clinical records.

At 20:00, the nursing notes record that Mrs Richards remained peaceful and sleeping but *"reacted to pain when being moved".* This was noted to be pain in both legs.

Panel comments – Box 7

- In addition to its intended effects, morphine might also have a number of side effects on a patient, including agitation and respiratory depression. The Panel has not seen any document in the clinical records to show that the nurses treating Mrs Richards understood or took into account these possible side effects of morphine when noting Mrs Richards' reaction to being moved. In this regard, the relevant nursing codes of conduct and standards required nurses to take every reasonable opportunity to maintain and improve knowledge and competence, including understanding the substances used when treating a patient.

On 19 August, the nursing notes record that Mrs Richards' grandson wished to speak with Dr Barton or Nurse Beed later that day, and that Mrs Richards' daughter was *"not happy with various aspects of care. Complaint to be handled officially by S Hutchings Nursing Co-ordinator."* The drug chart confirms that diamorphine 40 mg, midazolam 20 mg, haloperidol 5 mg and hyoscine 400 micrograms were administered by syringe driver at 11:20. There are no clinical notes on 19 August.

On 20 August, there are no clinical notes or nursing notes. The drug charts confirm that diamorphine, midazolam, hyoscine and haloperidol continued to be given to Mrs Richards until 21 August.

On 21 August, at 11:55, Dr Barton noted *"much more peaceful, needs Hyoscine for rattily chest"*. At 21:20, Staff Nurse Sylvia Giffin recorded Mrs Richards' death.

Case Study – Ethel Thurston

Summary of hospital admission

- In 1999, Ethel Thurston was aged 78 and was resident in a nursing home.
- On 15 June, she fell and fractured her left neck of femur. She was admitted to the Royal Hospital Haslar ('Haslar Hospital'), where she underwent a left cemented hemiarthroplasty (partial hip replacement).
- On 29 June, she was admitted to Gosport War Memorial Hospital for rehabilitation and mobilisation.
- On 16 July, she was noted to be much more settled.
- On 25 July, she vomited but was said to be a *"little brighter".*
- On 26 July, Miss Thurston died.

Background, care and treatment

In 1999, Miss Thurston was living in a nursing home. She had learning difficulties and was thought to have the mental capacity of a ten year old. Miss Thurston had once held down a job in a bank, was able to perform simple tasks and had been able to travel across London independently. She was long-sighted and wore glasses. Miss Thurston was said to have become aggressive from January 1999. In June, the nursing home had considered seeking a referral to a psychiatrist specialising in old age because of her aggression.

On 15 June, Miss Thurston fell in the dining room of the nursing home and was admitted to Haslar Hospital where she underwent a left cemented hemiarthroplasty (partial hip replacement).

On 24 June, Dr Richard Ian Reid assessed Miss Thurston at Haslar Hospital. He noted that her behaviour had:

> "… been difficult in that when asked to do things she was not keen to attempt to do, she is uncooperative and has been striking out at members of staff. She has been reluctant to eat and drink and has been hoisted in and out of bed or alternatively been transferred in and out of bed with the help of three nurses. I understand that she as incontinent and as a result was catheterised … when I saw her [Miss Thurston] was pleasant and cooperative. She smiled readily. I was unable to obtain any history from her as she appeared to have very limited vocabulary and/or was dysphasic. She was able to move both legs without pain and I was able to get her to attempt to stand. She was backward leaning and not taking her full weight through her legs, but she did not appear to be in any pain and my impression was that she had the physical potential to remobilise. However, whether she will do so will be very dependent on how she behaves. I think it would be appropriate to transfer to the War Memorial Hospital for a period of further assessment and hopefully remobilisation."

On 29 June, Miss Thurston was admitted to Gosport War Memorial Hospital for rehabilitation, care and mobilisation.

At the time of her admission to Gosport War Memorial Hospital, Miss Thurston was able to wash, dress and feed herself with encouragement and some help. Although she had a limited vocabulary, she had no difficulty in communicating. In addition to her fractured femur, Miss Thurston had an ulcer on her lower left leg, was prone to constipation and had in recent years become incontinent, which had necessitated the use of a catheter at Haslar Hospital. Miss Thurston's drug therapy was oxybutynin (for urinary incontinence) and zopiclone (a night sedative).

On 29 June, the admission nursing notes record Miss Thurston as demented with learning difficulties; in need of hoisting with *"no inclination to rehabilitate"*; very reluctant to take food and fluids; and *"willing to feed herself only if she feels like it"*. In addition, *"her behaviour can be aggressive and she has been known to strike staff".*

On 1 July, a fentanyl patch (25 micrograms) was prescribed by Dr Jane Barton. The prescription sheet records that the patch was to be given every three days. A fentanyl patch was administered on 1 July and then every three days. It was again prescribed on 7 July. The last patch was applied on 25 July.

Panel comments – Box 1

- Overall the Panel found a lack of detail in Miss Thurston's clinical records. The clinical notes, nursing notes and nursing care plans were generally scanty.
- It is clear from the clinical records that, on 29 June 1999, at the time of her transfer to Gosport War Memorial Hospital, Miss Thurston was not in pain or receiving any analgesia.
- The Panel has not found any entries in the clinical notes for 1 and 7 July. The care plan entries for this period are scanty.
- The Panel has not found any document in the clinical records to show that fentanyl was clinically indicated between 1 and 25 July.
- At the time of Miss Thurston's admission, accountability was an integral part of nursing practice. Nurses were accountable for their actions, and inactions, at all times. The relevant nursing professional codes of conduct and standards required nurses to scrutinise a prescription; question any ambiguity in the prescription; where they believed it necessary, refuse to administer a prescription; and report to an appropriate person or authority any circumstances which could jeopardise the standards of

practice or any concern about health services within their employing Health Authority or Trust. The codes and guidance made it clear that to silently tolerate poor standards is to act in a manner contrary to the interests of patients or clients, and contrary to personal professional accountability. Nurses were required to promote and protect the interests of patients.

- The Panel has not seen any document to confirm that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines to scrutinise the fentanyl prescription, or that they refused to administer the fentanyl patch at any time.
- The relevant nursing codes of conduct and standards required nurses to be able to justify any actions taken and to be accountable for the actions taken when administering or overseeing the administration of drugs. The Panel has not seen any document in the clinical records to show the reason or rationale for the decision to commence and continue the use of fentanyl.

On 7 July, a five-day course of oral antibiotics was prescribed and administered.

On 8 July, Miss Thurston was assessed by Dr Victoria Banks, a psychiatrist specialising in old age. She observed that Miss Thurston seemed to have dementia; however, she was less certain about whether Miss Thurston had depression and about any contribution that this was making to her current state. Dr Banks prescribed fluoxetine regularly and haloperidol as required. She also recommended that Miss Thurston's urinary catheter be removed and that she be treated with subcutaneous fluids and intravenous antibiotics. The nursing notes record that Dr Barton decided against intravenous antibiotics at that time.

Panel comments – Box 2

- It is not clear from the records why antibiotics were prescribed or why Dr Banks thought they should be administered intravenously. The records suggest that the indication was related to the catheter and/or the urinary tract.
- The records indicate that Miss Thurston's catheter was not removed until 11 July, when it became blocked.
- The Panel has not found any record to confirm that Miss Thurston was treated with subcutaneous fluids.
- The Panel notes that there was no facility at Gosport War Memorial Hospital for administering drugs and fluids intravenously.

On 13 July, Miss Thurston was re-catheterised.

On 16 July, Miss Thurston was noted to be *"much more settled"* with no change to her medication. The plan at that stage was to transfer her back to the nursing home.

On 19 July, Miss Thurston was seen by Dr Reid, who agreed with the plan for placement back in the nursing home. He noted that she had pain in her knees, was refusing oral analgesia and was *"better on fentanyl"*. He also noted that she was more settled and more cooperative at times.

Panel comments – Box 3

- The Panel has not seen any document in the clinical records to confirm the cause or degree of pain in Miss Thurston's knees on 19 July.
- There are no entries in the clinical notes from 19 July until 25 July. The care plan entries for this period are scanty. The nature of Miss Thurston's condition during this period is not clear.

On 25 July, the care plan entries record that Miss Thurston had vomited the previous evening; however, she was a *"little brighter"* that morning. The clinical notes confirm that Dr Beasley saw Miss Thurston later that day and noted: *"Refusing all fluids and food … turned face to the wall … problems with constipation, refuses painkiller-fentanyl patches only can be used."* The nursing notes record that *"Miss Thurston's Bowels had not been opened for 10 days and that subcutaneous fluids were commenced that morning … general condition seems to be deteriorating".*

On 26 July, Dr Barton saw Miss Thurston. She made a brief note in the clinical records – *"further deterioration overall … please keep comfortable. I am happy for nursing staff to confirm death"* – and prescribed diamorphine 20–200 mg and midazolam 20–200 mg to be administered by 24-hour subcutaneous infusion as required. The following record was made in the nursing notes: *"Syringe driver started diamorphine 90mg. Midazolam 20mg."* The drug chart records that these doses were administered at 11:15. At 19:00, a nurse confirmed Miss Thurston's death.

Miss Thurston's death certificate recorded the cause of death as bronchopneumonia and senile dementia.

Panel comments – Box 4

- The Panel has not seen any document in the clinical records to confirm the nature and extent of Miss Thurston's deterioration on 26 July.
- It was usual in the health service to use *"TLC"* or *"make comfortable"* as euphemisms for patients who were to be treated palliatively. It is not clear from the medical records why, on 26 July, Dr Barton requested nursing staff to keep Miss Thurston comfortable and why Dr Barton noted that she was *"happy for nursing staff to confirm death"* when Dr Reid had decided that Miss Thurston *"had the physical potential to remobilise"*. In addition, on 16 and 19 July, the plan was that she should return to a nursing home.
- At the time of Miss Thurston's admission, guidance from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Royal College of Nursing (RCN) (see Bibliography) emphasised the requirement for nurses to work in an open and cooperative manner with patients and their families. In this regard, the Panel has seen no documents in the clinical records to confirm that nurses engaged in any adequate end of life care discussion with Miss Thurston's family or carers.
- The Panel notes the prescribing of diamorphine and midazolam in high and very wide dose ranges on 26 July.
- The Panel has not found any document in the clinical records to show that diamorphine and midazolam were clinically indicated on 26 July.
- The Panel has not found any document in the clinical records to show that the fentanyl patch was removed at any point prior to the commencement of diamorphine. The Panel notes that if the fentanyl patch had been removed when diamorphine was commenced, it would have been clinically active for several days.
- The 90 mg starting dose of diamorphine was excessive, at least three times the recommended dose equivalent when changing from a fentanyl patch to subcutaneous diamorphine.
- The Panel has not seen any document to show that nurses consulted the British National Formulary (BNF) guidance or the Wessex guidelines to scrutinise the doses of diamorphine and midazolam; nor did they question any of the consultants, doctors or the pharmacist at Gosport War Memorial Hospital in respect of the prescription and doses, or refuse to administer the diamorphine and midazolam.
- The Panel has not seen any document in the clinical records to show the rationale for the decision to commence the diamorphine infusion at a dose of 90 mg over 24 hours on 26 July.
- The Panel has not seen any document in the clinical records to show that nurses consulted the BNF guidance, the Wessex guidelines, any doctor or the pharmacist when commencing the administration of diamorphine at 90 mg.

- The Panel has not seen any document to show that nurses were provided with any written guidance from the doctors, consultants or Portsmouth HealthCare NHS Trust on when to commence the administration of diamorphine and midazolam or the choice of starting dose.
- At the time of Miss Thurston's admission, the UKCC guidance required nurses to carry out a comprehensive assessment of the patient's nursing requirements, and devise, implement and keep under review care plans. The UKCC guidance also required nurses to create and maintain clinical records in order to provide accurate, current, comprehensive and concise information concerning the condition and care of the patient. Such records would include: details of observations, problems, evidence of care required, action taken, intervention by practitioners, patient responses, factors that appeared to affect the patient, the chronology of events, and reasons for any decision. These records would provide a baseline against which improvement or deterioration could be judged. Among other elements of care, *"Through their role in drug administration nurses are in an ideal position to monitor the drugs progress, reporting responses and side effects".* In this regard, the Panel found a lack of information in Miss Thurston's daily nursing notes and care plans. The nursing notes and care plans seen by the Panel were scanty, were not personalised to the patient's needs and contained missing entries for entire days. For example, the 'Urinary Incontinence Care Plan' required daily evaluation; however, entries were made on five days only. There was nothing in the care plans that took account of Miss Thurston's cognitive impairment, capabilities, likes, dislikes and preferences. The Panel found no pain charts or pain management plans in Miss Thurston's medical records. It is not clear to the Panel how Miss Thurston's pain and the effectiveness of any analgesia were adequately monitored.
- The Panel has not seen any nutrition or fluid charts among Miss Thurston's clinical records. Fluid and nutritional intake is an important part of the clinical picture. Fentanyl, diamorphine and midazolam could impair Miss Thurston's ability to eat and drink.
- In addition to its intended effects, morphine might also have a number of side effects on a patient, including discomfort, agitation and respiratory depression. The Panel has not seen any document in the clinical records to show that the nurses treating Miss Thurston understood or took into account these possible side effects of morphine when noting Miss Thurston's condition. In this regard, the relevant nursing codes of conduct and standards required nurses to take every reasonable opportunity to maintain and improve knowledge and competence, including understanding the substances used when treating a patient.
- The Panel has not found any document in the medical records to show any evidence of bronchopneumonia.
- The Panel has not found any document in the medical records to show that any discussion took place with Miss Thurston's family or carers about her treatment.
- Miss Thurston died approximately eight hours after the first, large and only dose of diamorphine.

Bibliography

Key United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) policy documents

The Code of Professional Conduct for Nurses, Midwives and Health Visitors (3rd edition), 1992

The Scope of Professional Practice, 1992

Standards for the Administration of Medicines, 1992

Professional Conduct – Occasional Report on Selected Cases 1 April 1991 to 31 March 1992, 1992

Professional Conduct – Occasional Report on Standards of Nursing in Nursing Homes, 1994

The Future of Professional Practice: The Council's Standards for Education and Practice Following Registration, 1994

Position Statement on Clinical Supervision for Nursing and Health Visiting, 1996

The Continuing Care of Older People, UKCC Policy Paper 1, 1997

Guidelines for Records and Record Keeping, 1998

These documents identify the regulator's expectations with regard to:

- professional conduct
- accountability
- scope of practice
- administration of medicines
- record keeping
- clinical supervision
- continuing professional development.

Key Department of Health document over this period

Clinical Supervision for the Nursing and Health Visiting Professions. CNO Letter 94(5), 1994

Key Royal College of Nursing (RCN) documents over this period

'A scandal waiting to happen?', pp18–20 in *Elderly People and Nursing Care in Residential and Nursing Homes*, 1992

Guidelines for Assessing Mental Health Needs in Old Age, 1993

Older People and Continuing Care: The Skill and Value of the Nurse, 1993

The Value and Skill of Nursing: Working with Older People, 1993

Nursing and Older People: Report of the RCN Taskforce on Nursing and Older People, 1995

The Value and Skills of Nurses Working with Older People, 1996

Nursing Homes: Nursing Values, 1996

Combating Abuse and Neglect of Older People: RCN Guidelines for Nurses, 1996

What a Difference a Nurse Makes: *an RCN Report on the Benefits of Expert Nursing to the Clinical Outcomes in the Continuing Care of Older People*, 1997

Appendix 3: Gosport Independent Panel – Terms of Reference

1.1 Concerns about the care of older patients in Gosport War Memorial Hospital have been the subject of scrutiny since 1998. Families of those who died have persistently sought a full and independent investigation into the circumstances surrounding the death of their relatives and into the care they received prior to death.

1.2 There have been numerous investigations into the events surrounding these deaths: three police investigations, a Commission for Health Improvement investigation; a General Medical Council (GMC) inquiry; the Council for Healthcare Regulatory Excellence review and inquests into eleven deaths at the hospital. In 2010, after reviewing the material from the ten inquests and the GMC proceedings, the Crown Prosecution Service (CPS) concluded that 'the evidence is insufficient to provide a realistic prospect of conviction for an offence of gross negligence manslaughter …. in respect of each of the ten deaths reviewed.'

1.3 In 2013, the Department of Health published a clinical audit of care which had taken place in 2003 by Professor Richard Baker covering the period 1988-2000. The report 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 …. 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'.

1.4 For the families, there remain unanswered questions about the care of their relatives, the circumstances surrounding their treatment and death and the slow progress of the various investigations.

1.5 In light of this, Norman Lamb, the-then Minister of State for Care and Support at DH established the Gosport Independent Panel, under the chairmanship of Bishop James Jones, to review the documentary evidence held across a range of organisations concerning the initial care of families' relatives and the subsequent investigations into their deaths in Gosport War Memorial Hospital.

Terms of reference

1.6 The Government is committed to maximum possible public disclosure of the documentation relating to the events at Gosport War Memorial Hospital from all possible sources.

1.7 The remit of the independent panel is to:

- Consult with the families of the deceased and of those treated to ensure that the views of those affected are taken into consideration;
- Obtain, examine and analyse documentation from all relevant organisations and individuals (governmental and non-governmental) to include:
  a) Undertaking the review of historic health and social care records to establish treatment prior to death and the care of the elderly and vulnerable in the hospital;
  b) Examining the role of Gosport War Memorial Hospital and Redclyffe Annexe management, both clinical and administrative, and staff and other health and social care organisations. This will include their response to any concerns which were raised with them;
  c) Reviewing all investigations related to complaints made to and concerns raised with all other relevant organisations and individuals;
  d) Reviewing the relationships between the different investigations and their relationship with the families.

1.8 The Gosport Independent Panel will:

- Oversee the maximum possible public disclosure of all relevant information relating to unexpected deaths and treatment at the Gosport War Memorial Hospital;
- Manage the process of public disclosure, initially to the affected families;
- Produce a report which will provide an overview of the information reviewed by the panel and will illustrate how the information disclosed adds to public understanding of these events and their aftermath.
- Establish an on-line archive of Gosport documentation, including a catalogue of all relevant information and a commentary on any information withheld for the benefit of the families or on legal or other grounds.

1.9 The review by the Independent Panel is expected to complete by spring 2018. The Secretary of State for Health will make arrangements for publication of the final report to Parliament.

Table 1

Summary findings from clinical records of patients in the Initial Group

Patient information						Further information		Diamorphine							Midazolam	Hyoscine	Fentanyl	
Patient surname	Patient first name(s)	Date of birth	Date of admission to GWMH	Date of death on certificate	Age at death	Cause of death as given by certifying doctor	Was patient admitted for terminal care?	Diamorphine administered?	Stated reason for administering diamorphine	Diamorphine first dose date	Initial dose of diamorphine (mg/24 hours)	Diamorphine final dose date	Final dose of diamorphine (mg/24 hours)	Length of time diamorphine given by syringe driver (days)	Midazolam administered?	Hyoscine administered?	Fentanyl administered?	Panel assessment: opioid usage without appropriate clinical indication?
Abbatt	Victor	26/06/1912	29/05/1990	30/05/1990	77	1(a) Congestive cardiac failure 1(b) Bronchopneumonia	NO	NO							NO	NO	NO	
Amey	Dennis	07/11/1928	14/11/1990	20/12/1990	62	1(a) Bronchopneumonia 2 Parkinson's disease	NO	YES	None stated	11/12/1990	120			1		NO	NO	YES
Attree	Lily	26/03/1917	26/07/1996	24/08/1996	79	1(a) Bronchopneumonia 2 Metastatic carcinoma of tongue	NO	YES	Pain	20/08/1996	50	23/08/1996	75	4	YES	YES	NO	
Aubrey	Edith	28/09/1911	06/11/1994	15/06/1996	84	1(a) Bronchopneumonia 2 Senile dementia	NO	YES	Pain	07/06/1996	60	13/06/1996	90	7	YES	NO	YES	YES
Aubrey	Henry	08/08/1911	01/06/1999	02/06/1999	87	1(a) Carcinoma of bronchus	NO	YES	No clear reason	02/06/1999	60	02/06/1999	60	<1	YES	YES	YES	YES
Baker	Ellen	15/06/1910	07/11/1990	09/11/1990	80	1(a) Congestive cardiac failure 1(b) Atrial fibrillation 1(c) Ischaemic heart disease 2 Paget's disease	NO	YES	Pain	08/11/1990	5 (single dose IV)	08/11/1990	5		NO	NO	NO	
Barker	Alice Constance	02/03/1911		29/01/1996	84	1(a) Myocardial ischaemia 1(b) Coronary atheroma												
Barnes	Ronald Percy	09/08/1915	20/01/1995	22/05/1995	79	1(a) Bronchopneumonia 2 Parkinson's disease	NO	YES	Pain	22/05/1995	40	22/05/1995	40	<1	YES	YES	NO	YES
Batty	Charles	30/12/1913	26/04/1993	02/01/1994	80	1(a) Bronchopneumonia 2 Parkinson's disease	NO	YES	No clear reason	30/12/1993	40	01/01/1994	40	3	YES	YES	NO	YES
Blood	Emma	09/11/1902		01/07/1994	91	1(a) Congestive cardiac failure 1(b) Atrial fibrillation 1(c) Ischaemic heart disease 2 Paget's disease		NO								NO	NO	
Bowers	Reginald	12/10/1912		02/01/1999	86	1(a) Acute myocardial ischaemia 2 Coronary artery atheroma		NO								NO	NO	
Boxall	Albert John	15/09/1915		09/08/1996	80	1(a) Pulmonary congestion 1(b) Dilated cardiomyopathy												
Brennan	Irene	03/07/1910	10/06/1998	01/07/1998	87	1(a) Bronchopneumonia 1(b) Cerebrovascular accident		YES	Pain	29/06/1998	60	Records incomplete	60	3	NO	NO	YES	YES
Brickwood	Dennis	09/11/1917	03/02/1998	12/06/1998	80	1(a) Carcinomatosis 1(b) Carcinoma of prostate	NO	YES	No clear reason	10/06/1998	60	12/06/1998	60	1	YES	YES	NO	YES
Bufton	Gwendolene	11/04/1918	25/11/1998	11/02/1999	80	1(a) Congestive cardiac failure 1(b) Cor pulmonale 1(c) Mitral valve stenosis 2 Chronic renal failure	NO (documented poor prognosis on admission)	NO							NO	NO	YES	
Caldwell	Alfred	01/01/1916	23/03/1992	03/04/1992	76	1(a) Congestive cardiac failure 1(b) Chronic obstructive airways disease	NO	YES	Records incomplete	Records incomplete	Records incomplete	03/04/1992	Records incomplete	<1	Records incomplete	Records incomplete	Records incomplete	
Carby	Stanley Eric	31/12/1933	26/04/1999	27/04/1999	65	1(a) Cerebrovascular accident	NO	YES	None stated	27/04/1999	40	27/04/1999	40	<1	YES	NO	NO	YES
Carter	Edwin Henry George	21/01/1901	08/11/1993	24/12/1993	92	1(a) Bronchopneumonia 2 Carcinoma of stomach	NO	YES	Condition deteriorating	22/12/1993	80	24/12/1993	100	2	YES	YES	NO	
Chambers	Annie Dorothy	26/07/1922	24/02/1998	06/03/1998	75	1(a) Cerebrovascular accident	NO	YES	No clear reason	04/03/1998	40	05/03/1998	40	2	YES	YES	NO	YES
Chilvers	Edith	18/07/1903	02/10/1988	19/08/1990	87	1(a) Cerebrovascular accident 2 Cerebral arteriosclerosis	NO	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	
Chivers	Sidney	01/11/1919	06/04/99 and 11/05/1999	20/06/1999	79	1(a) Bronchopneumonia	NO	YES	No clear reason	19/06/1999	40	20/06/1999	60	2	YES	YES	YES	YES
Clarke	Hubert	01/04/1906	05/06/2000	17/06/2000	94	1(a) Bronchopneumonia 1(b) Cerebrovascular accident	NO	YES	Pain	08/06/2000	5 (single dose)	16/06/2000	5	3	NO	NO	NO	
Coates	Peggy Joan	09/05/1923	02/06/1999	15/07/1999	76	1(a) Bronchopneumonia 2 Cerebrovascular accident	NO	YES	No clear reason (unrousable)	14/07/1999	20	15/07/1999	40	2	YES	YES	YES	YES
Cooper	Albert Edward	23/07/1917	25/03/1998	05/04/1998	80	1(a) Carcinoma of prostate 2 Cerebral vascular insufficiency	NO	YES	None stated	01/04/1998	40	04/04/1998	40	3	YES	YES	NO	YES
Corke	James Vivian	07/02/1915	21/07/1989	14/08/1989	74	1(a) Renal failure 1(b) Septicaemia 1(c) Urinary tract infection 2 Parkinson's disease	NO	NO							NO	NO	NO	

Patient information						Further information		Diamorphine							Midazolam	Hyoscine	Fentanyl	
Patient surname	Patient first name(s)	Date of birth	Date of admission to GWMH	Date of death on certificate	Age at death	Cause of death as given by certifying doctor	Was patient admitted for terminal care?	Diamorphine administered?	Stated reason for administering diamorphine	Diamorphine first dose date	Initial dose of diamorphine (mg/24 hours)	Diamorphine final dose date	Final dose of diamorphine (mg/24 hours)	Length of time diamorphine given by syringe driver (days)	Midazolam administered?	Hyoscine administered?	Fentanyl administered?	Panel assessment: opioid usage without appropriate clinical indication?
Cousins	Arthur Albert	31/03/1918	10/07/2000	25/08/2000	82	1(a) Chronic obstructive pulmonary disease 2 Small cell carcinoma of lung	NO	YES	Pain (oral morphine not effective)	21/08/2000	10	24/08/2000	40	4	YES	YES	NO	
Cresdee	Olive	29/12/1920	03/04/1990	02/06/1990	69	1(a) Bronchopneumonia 1(b) Carcinomatosis	NO	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	
Cresdee	Ronald	10/11/1917	17/06/1996	07/07/1996	78	1(a) Carcinoma of bronchus	YES	YES	None stated	07/07/1998	50	07/07/1998	100	1		YES	NO	
Cunningham	Arthur Brian	12/03/1919	21/09/1998	26/09/1998	79	1(a) Bronchopneumonia	NO	YES	Pain	21/09/1998	20	26/09/1998	80	5	YES	YES	NO	YES
Davis	Muriel Jeanne	05/08/1920	29/08/1999	30/08/1999	79	1(a) Carcinoma sigmoid colon	YES	YES	Pain (when roused)	30/08/1999	10	30/08/1999	10	<1	NO	YES	NO	
Deacon	Kate Edith	20/01/1901		12/05/1993	92	1(a) Cerebrovascular accident	NO	YES	Distress and haemorrhage	12/05/1993	40	12/05/1993	40	<1	YES	YES	NO	YES
Dent	William John	05/09/1926	19/09/1999	10/10/1999	73	1(a) Leiomyosarcoma of buttock with lung metastases	NO	YES	None stated	19/09/1999	20	19/09/1999	20	<1		NO	NO	
Devine	Elsie	26/06/1911	21/10/1999	21/11/1999	88	1(a) Chronic renal failure 2 Chronic glomerulonephritis	NO	YES	None stated	19/11/1999	40	21/11/1999	60	3	YES	NO	YES	YES
Dicks	Cyril	17/03/1914	28/12/1998	22/03/1999	85	1(a) Bronchopneumonia	NO	YES	Pain (when being turned in bed)	20/03/1999	20	Records incomplete	Records incomplete	Records incomplete	YES	NO	NO	
Docherty	Doris Catherine	11/05/1919		08/08/1997	78	1(a) Cerebrovascular accident 2 Cervical myelopathy	NO	YES	Pain	30/07/1997	20	08/08/1997	90	10	YES	YES	NO	
Donoghue	Mary Constance	16/02/1924	16/05/1991	03/08/1991	67	1(a) Carcinomatosis 1(b) Carcinoma of rectum 2 Cerebrovascular accident		YES	No clear reason	25/07/1991	60		150	7	NO	NO	NO	
Doughty	Dennis Robert	15/06/1938		13/05/2000	61	1(a) Carcinoma of caecum with metastases												
Douthwaite	Freda	01/09/1931	14/10/1999	06/11/1999	68	1(a) Cerebrovascular accident	NO	YES	Discomfort	04/11/1999	80	05/11/1999	80	2	YES	YES	YES	YES
Dumbleton	Harry	08/01/1914		12/06/1993	79	1(a) Bronchopneumonia 2 Cerebrovascular atherosclerosis	NO	YES	Deterioration and difficulty swallowing	11/06/1993	40	11/06/1993	40	<1	YES	YES	NO	YES
Elbourn	Daisy Elizabeth	09/03/1915	13/06/1998	14/08/1998	83	1(a) Cerebrovascular accident	NO	YES	Pain	12/08/1998	30	13/08/1998	60	2	YES	YES	NO	YES
Ellis	Kathleen	09/05/1914	24/06/1999	05/07/1999	85	1(a) Cerebrovascular accident	NO	NO							YES	NO	NO	
Evans	David Francis	12/06/1912		21/04/1991	78	1(a) Carcinomatosis 1(b) Carcinoma of the stomach 2 Maturity onset diabetes mellitus												
Farmer	Edith May	31/12/1905		28/09/1996	90	1(a) Cerebrovascular accident 2 Senile dementia												
Feben	Doris Lilian Greta	27/01/1905	16/02/1998	25/02/1998	93	1(a) Cerebrovascular accident	NO	YES	Pain (oral medication not well tolerated)	24/02/1998	50	Unclear	50	1	YES	YES	NO	YES
Fletcher	Harold Richard	26/12/1926	04/11/1997	04/02/1998	71	1(a) Carcinoma of prostate	NO	YES	Pain (when moved)	02/02/1998	20	04/02/1998	100	2	YES	YES	NO	
Flynn	Dorothy Edith	20/01/1913		21/02/1993	80	1(a) Bronchopneumonia 1(b) Pulmonary fibrosis												
Gamblin	Frederick Thomas	11/01/1915	29/11/1999	02/01/2000	84	1(a) Carcinomatosis 1(b) Carcinoma of oesophagus	NO	NO							NO	NO	NO	
Gascoigne	Eileen Caroline	xx/xx/1906		06/07/1982	77	1(a) Left ventricular failure 1(b) Coronary atherosclerosis 2 Cerebrovascular disease												
German	Mary	08/09/1920	28/11/1998	03/12/1998	78	1(a) Small cell lung cancer	NO	YES	None stated	02/12/1998	30	02/12/1998	30	1	NO	YES	NO	
Gilbert	Ethel May	17/10/1906		19/04/1997	90	1(a) Myocardial infarction												
Godley	Bertha Millicent	28/10/1910		01/05/1987	76	1(a) Bronchopneumonia												
Gonella	Nathaniel	07/03/1908	30/07/1998	06/08/1998	90	1(a) Ischaemic heart disease	NO	YES	Agitation and distress	03/08/1998	20	06/08/1998	200	1	YES	YES	NO	YES
Graham	Leonard	12/10/1924	04/09/2000	14/09/2000	75	1(a) Bronchopneumonia 1(b) Lewy body dementia	NO	YES	Suspected pulmonary embolism	14/09/2000	2.5 (single dose)	14/09/2000	2.5		NO	NO	NO	
Gregory	Sheila	12/07/1908	03/09/1999	22/11/1999	91	1(a) Bronchopneumonia	NO	YES	No clear reason	21/11/1999	20	21/11/1999	20	1	NO	NO	NO	YES
Gregory	Vernon	30/12/1914		02/07/1989	74	1(a) Bronchopneumonia 1(b) Parkinson's disease 2 Carcinoma of colon												
Hadley	Harry	17/08/1914	05/10/1999	10/10/1999	85	1(a) Carcinoma of bladder with metastases	YES	YES	Pain reported but unclear rationale	07/10/1999	60	10/10/1999	60	3	NO	YES	NO	YES

Patient information						Further information		Diamorphine							Midazolam	Hyoscine	Fentanyl	
Patient surname	Patient first name(s)	Date of birth	Date of admission to GWMH	Date of death on certificate	Age at death	Cause of death as given by certifying doctor	Was patient admitted for terminal care?	Diamorphine administered?	Stated reason for administering diamorphine	Diamorphine first dose date	Initial dose of diamorphine (mg/24 hours)	Diamorphine final dose date	Final dose of diamorphine (mg/24 hours)	Length of time diamorphine given by syringe driver (days)	Midazolam administered?	Hyoscine administered?	Fentanyl administered?	Panel assessment: opioid usage without appropriate clinical indication?
Hall	Charles	04/09/1903	05/07/1993	06/08/1993	89	1(a) Bronchopneumonia 1(b) Senile dementia	NO	YES	Pain	05/08/1993	40	05/08/1993	40	1	YES	YES	NO	YES
Hall	Norah Kathleen	03/02/1916	01/06/1999	19/06/1999	83	1(a) Carcinoma of the stomach	YES	YES	Pain	01/06/1999	10	19/06/1999	20	16	NO	YES	NO	
Hames	Evelyn	24/09/1914	09/06/2000	25/06/2000	85	1(a) Cerebrovascular accident	NO	NO							NO	YES	NO	
Hardman	Mabel	31/05/1910		18/04/1995	84	1(a) Cerebrovascular accident												
Harrington	Wilfred	13/02/1905	08/06/1993	21/07/1993	88	1(a) Cerebrovascular accident	NO	YES	Pain (hip fracture)	21/07/1993	40	21/07/1993	40	<1		YES	NO	YES
Hill	Edith Daisy	26/01/1912	08/11/1998	15/11/1998	86	1(a) Bronchopneumonia 1(b) Congestive cardiac failure 1(c) Aortic stenosis	NO	YES	Distress	10/11/1998	20	15/11/1998	20	<1	YES	YES	NO	YES
Hill	Percy James William	22/09/1910	21/11/1994	01/01/1995	84	1(a) Bronchopneumonia	NO	YES	Chest pain and cyanosis	30/12/1994	40	01/01/1995	40	<1	YES	YES	NO	YES
Hillier	Eileen Maude	11/02/1919	23/05/1995	01/08/1995	76	1(a) Cardiac failure 1(b) Haemorrhage 1(c) Carcinoma of breast 2 Depression	NO	YES	Distress (severe)	31/07/1995	35	01/08/1995	45		NO	NO	NO	
Hobbs	Marjorie	15/12/1914	18/08/1999	09/09/1999	84	1(a) Carcinomatosis 1(b) Spindle cell sarcoma mesocolon	NO	YES	Pain and vomiting	02/09/1999	20	09/09/1999	40	5	NO	YES	NO	
Hobday	Alan	05/12/1922	24/07/1998	11/09/1998	75	1(a) Bronchopneumonia 2 Cerebrovascular accident	NO	YES	None stated	08/09/1998	20	11/09/1998	40	4	YES	YES	NO	YES
Hogarth	John	22/03/1912		01/02/1981	68	Record not found		NO								NO	NO	
Hooker	Annie Violet	15/12/1903	08/09/1987	08/09/1987	83	1(a) Myocardial infarction 2 Carcinoma of stomach	YES	NO							NO	NO	NO	
Hooper	Albert	11/03/1910	12/09/2000	09/10/2000	90	1(a) Bronchopneumonia	NO	YES	Pain	10/07/2000	10	09/10/2000	20	2	YES	YES	NO	
Horn	Frank	15/07/1909	05/11/1999	12/11/1999	90	1(a) Bronchopneumonia	NO	YES	Distress and coughing fit	10/11/1999	20	12/11/1999	40	2	YES	YES	NO	YES
Horne	Phyliss	05/02/1916	26/03/1998	06/05/1998	82	1(a) Senile dementia		NO								NO	NO	
Houghton	Clifford	25/02/1922	31/01/1994	06/02/1994	71	1(a) Cerebrovascular accident 2 Senile dementia	NO	YES	Deterioration	06/02/1994	40	06/02/1994	60	1	YES	YES	NO	YES
Howard	Norah Kathleen	22/10/1924		30/12/1998	74	1(a) Metastatic carcinoma 1(b) Breast carcinoma												
Hurnell	Joan Mary	03/04/1922	14/05/1999	18/05/1999	77	1(a) Carcinomatosis (from carcinoma of left breast)	NO	NO							NO	NO	NO	
Hutfield	Lilian Norah	24/09/1918	27/04/1997	13/06/1997	78	1(a) Bronchopneumonia 2 Cerebrovascular accident	NO	YES	Deterioration (possibly due to cerebrovascular accident)	10/06/1997	20	Illegible	40		YES	YES	NO	YES
Jarman	Thomas	10/06/1902	27/10/1997	10/11/1999	97	1(a) Bronchopneumonia 2 Hairy cell leukaemia	NO	YES	Deterioration	08/11/1999	20	10/11/1999	60	3	YES	YES	NO	YES
Kiln	Bernard John	08/01/1910	08/04/1988	11/04/1988	78	1(a) Bronchopneumonia	NO	NO							NO	NO	NO	
Kynoch	Olive Marion	03/06/1908	29/09/1998	22/10/1998	90	1(a) Bronchopneumonia 2 Senile dementia	NO	YES	Distress and deterioration	21/10/1998	20	22/10/1998	20	2	YES	YES	NO	YES
Lake	Ruby	23/10/1913	18/08/1998	21/08/1998	84	1(a) Bronchopneumonia	NO	YES	Pain	19/08/1998	20	20/08/1998	20	2	YES	YES	NO	YES
Lavender	Elsie	04/11/1912	22/02/1996	06/03/1996	83	1(a) Cerebrovascular accident 2 Diabetes mellitus	NO	YES	Pain	05/03/1996	100	06/03/1996	100	2	YES	NO	NO	YES
Lawrence	Violet	01/03/1909	08/07/1998	30/07/1998	89	1(a) Congestive cardiac failure 2 Chronic renal failure	NO	YES	Deterioration, nausea and discomfort	30/07/1998	20	30/07/1998	20	<1	YES	YES	NO	YES
Lee	Alfred HN	21/10/1907		09/05/1996	88	1(a) Cerebrovascular accident 2 Senile dementia	NO	YES	Deterioration	09/05/1996	40	09/05/1996	40	<1	YES	YES	YES	YES
Lee	Catherine	05/05/1906	14/04/1998	26/05/1998	92	1(a) Bronchopneumonia	NO	YES	Deterioration and discomfort	21/05/1998	20	26/05/1998	40	6	YES	NO	YES	YES
Leek	Mabel	27/02/1906	06/08/1998	18/12/1998	92	1(a) Bronchopneumonia	NO	YES	Deterioration, unresponsive but pain on being moved	14/12/1998	80	18/12/1998	160	4	YES	YES	NO	YES
Lodder	Molly Beryl	11/07/1930		20/12/2000	70	1(a) Alzheimer's disease 2 Urinary tract infection, chronic obstructive pulmonary disease												
Marshall	Rhoda	30/06/1911	28/12/1995	07/01/1996	84	1(a) Bronchopneumonia	NO	YES	Pain on being moved	02/01/1996	40	07/01/1996	120	6	YES	YES	NO	YES
Martin	Stanley	22/04/1913	06/01/1998	08/01/1998	84	1(a) Bronchopneumonia	NO	YES	Deterioration	07/01/1998	5 (single dose)	07/01/1998			NO	NO	NO	

Patient information						Further information		Diamorphine							Midazolam	Hyoscine	Fentanyl	
Patient surname	Patient first name(s)	Date of birth	Date of admission to GWMH	Date of death on certificate	Age at death	Cause of death as given by certifying doctor	Was patient admitted for terminal care?	Diamorphine administered?	Stated reason for administering diamorphine	Diamorphine first dose date	Initial dose of diamorphine (mg/24 hours)	Diamorphine final dose date	Final dose of diamorphine (mg/24 hours)	Length of time diamorphine given by syringe driver (days)	Midazolam administered?	Hyoscine administered?	Fentanyl administered?	Panel assessment: opioid usage without appropriate clinical indication?
Middleton	Dulcie	28/08/1915	29/05/2001	02/09/2001	86	1(a) Bronchopneumonia 2 Cerebrovascular accident	NO	NO							NO	NO	NO	
Midford-Millership	Douglas	14/05/1917	08/07/1999	20/07/1999	82	1(a) Cerebrovascular accident 2 Congestive cardiac failure	NO	NO							NO	NO	NO	
Mihalop	Nora	12/01/1916	24/03/1999; moved to Daedalus Ward 08/04/1999	18/04/1999	83	1(a) Ischaemic heart disease	NO	YES	Pain	15/04/1999	2.5 (single dose)	15/04/1999	2.5		NO	NO	NO	
Moorman	Maud Nora Gladys	22/01/1916		27/07/2001	85	1(a) Bronchopneumonia 1(b) Peripheral vascular disease 1(c) Ischaemic heart disease 2 Hypertension												
Murphy	Ethel Beatrice	04/07/1916	09/03/1999	23/03/1999	82	1(a) Bronchopneumonia 1(b) Cerebrovascular disease	NO	YES	Agitation and discomfort (noisy)	18/03/1999	20	23/03/1999	30	6	NO	YES	NO	YES
Neill	Julia Irene	16/12/1915	29/06/1999	12/08/1999	83	1(a) Congestive cardiac failure 1(b) Senile myocardial degeneration	NO	YES	Distress	08/08/1999	20	12/08/1999	60	5	YES	NO	NO	YES
Packman	Geoffrey	15/04/1932	23/08/1999	03/09/1999	67	1(a) Myocardial infarction	NO	YES	No clear reason	26/08/1999	40	02/09/1999	90	8	YES	NO	NO	YES
Page	Eva	28/12/1909	27/02/1998	03/03/1998	88	1(a) Carcinomatosis 2 Carcinoma of bronchus	Unclear	YES	Pain (and fear)	02/03/1998	10 (two IM doses)	03/03/1998	20		YES	NO	YES	YES
Parr	Gwendoline Margaret	04/11/1912	31/12/1998	29/01/1999	86	1(a) Bronchopneumonia	NO	YES	Deterioration and agitation	25/01/1999	20	29/01/1999	20	5	YES	YES	YES	YES
Perkins	Marjorie Ann	26/01/1917		12/09/1998	81	1(a) Bronchopneumonia 2 Dementia		NO								NO	NO	
Pope	William Thomas	02/11/1923	28/08/1990	10/09/1990	66	1(a) Cerebral infarction 1(b) Hypertension 2 Multi infarct dementia		NO								NO	NO	
Queree	Margaret	22/08/1910	29/07/1994	10/10/1994	84	1(a) Bronchopneumonia	NO	YES	Agitation and confusion	06/10/1994	40	09/10/1994	80	3	YES	YES	NO	YES
Ramsay	Joan	24/10/1920	01/06/2001	13/12/2001	81	1(a) Chronic renal failure 1(b) Hypertension – diabetes mellitus 2 Anaemia	NO	NO							NO	NO	NO	
Reeve	Violet	04/04/1921	08/11/1996; moved to Daedalus Ward 11/11/1996	14/04/1997	76	1(a) Bronchopneumonia 2 Cerebrovascular accident	NO	YES	Distress	07/04/1997	20	14/04/1997	60	7	YES	YES	NO	YES
Richards	Gladys	13/04/1907	11/08/1998 and 17/08/1998	21/08/1998	91	1(a) Bronchopneumonia	NO	YES	Pain	18/08/1998	40	21/08/1998	40	4	YES	YES	NO	YES
Ripley	James	23/09/1924	02/04/2000	18/01/2007	82	Record not found	NO	NO							NO	NO	NO	
Roderick	Peter Powell	26/03/1925		23/02/1993	67	1(a) Cerebrovascular accident 2 Parkinson's disease		NO								NO	NO	
Rogers	Elizabeth Finegan	10/06/1929	30/01/1997	04/02/1997	67	1(a) Cerebrovascular accident 2 Parkinson's disease	NO	YES	Pain (not controlled by oral morphine)	03/02/1997	40	04/02/1997	60	2	YES	YES	NO	YES
Sandford	Hazel Felicity	10/10/1910	12/12/1990	25/12/1990	80	1(a) Bronchopneumonia 1(b) Cerebrovascular disease	NO	NO								NO	NO	
Saunders	John Seymour	24/12/1911		08/12/1998	86	1(a) Bronchopneumonia 1(b) Dementia 2 Ischaemic heart disease and chronic renal failure		NO								NO	NO	
Sawford	Mary Theresa	28/07/1928		28/02/2006	77	Record not found		NO								NO	NO	
Scovell	Ruby	06/10/1922		05/07/1998	75	1(a) Bronchopneumonia 2 Depression	NO	YES	Pain (and deterioration)	01/07/1998	40	04/07/1998	40	4	YES	NO	YES	YES
Service	Helena	02/02/1898	03/06/1997	05/06/1997	99	1(a) Congestive cardiac failure	NO	YES	Restless	04/06/1997	20	04/06/1997	20	<1	YES	NO	NO	YES
Skeens	Euphemia	08/06/1908	20/10/1995	29/10/1995	87	1(a) Cerebrovascular accident	NO	YES	Restlessness and discomfort	28/10/1995	40	29/10/1995	40	1	YES	YES	NO	YES
Slaymaker	Hester	22/09/1913		01/04/1993	79	1(a) Adenocarcinoma endometrium												
Smith	Grace	09/02/1902	02/09/1995	03/09/1995	93	1(a) Bronchopneumonia		NO								NO	NO	

Patient information						Further information		Diamorphine							Midazolam	Hyoscine	Fentanyl	
Patient surname	Patient first name(s)	Date of birth	Date of admission to GWMH	Date of death on certificate	Age at death	Cause of death as given by certifying doctor	Was patient admitted for terminal care?	Diamorphine administered?	Stated reason for administering diamorphine	Diamorphine first dose date	Initial dose of diamorphine (mg/24 hours)	Diamorphine final dose date	Final dose of diamorphine (mg/24 hours)	Length of time diamorphine given by syringe driver (days)	Midazolam administered?	Hyoscine administered?	Fentanyl administered?	Panel assessment: opioid usage without appropriate clinical indication?
Smith	Horace Reuben David	02/05/1925	30/03/1999 (returned to Haslar Hospital 31/03/1999)	06/04/1999	73	1(a) Acute pancreatitis		YES	Ventilation	05/04/1999	Records incomplete	Unknown – ITU charts not present	Records incomplete	Records incomplete	NO	NO	NO	
Spurgin	Enid Phyllis Dormer	16/02/1907	26/03/1999	13/04/1999	92	1(a) Cerebrovascular accident	NO	YES	Pain	12/04/1999	80	13/04/1999	40	2	YES	NO	NO	YES
Stanford	Dorothy	13/10/1915	23/11/1993	27/11/1993	78	1(a) Cerebrovascular accident	NO	YES	No clear reason	25/11/1993	40	26/11/1993	40	2	YES	YES	NO	YES
Stevens	Jean	28/06/1925	20/05/1999	22/05/1999	73	1(a) Cerebrovascular accident	NO	NO								NO	NO	
Stott	Irene Florence	18/06/1914		30/09/1996	82	1(a) Ventricular fibrillation 1(b) Ischaemic heart disease 2 Femoral embolus		NO								NO	NO	
Sutton	Josephine Margaret Doris	15/09/1909	29/11/1999	25/12/1999	90	1(a) Bronchopneumonia	NO	YES	Pain	22/12/1999	20	25/12/1999	40	4	YES	NO	NO	
Tampling	Ada Florence	13/10/1898	09/02/1998	15/04/1998	99	1(a) Bronchopneumonia	NO	YES	No clear reason (one mention of back pain)	15/04/1998	40	15/04/1998	40	<1	YES	YES	YES	YES
Taylor	Daphne	26/12/1925	03/10/1996	20/10/1996	70	1(a) Bronchopneumonia 2 Cerebrovascular accident	NO	YES	Pain	17/10/1996	40	19/10/1996	40	3	YES	YES	YES	YES
Taylor	Lillian	11/12/1915	21/01/2000	14/02/2000	84	1(a) Carcinomatosis 1(b) Carcinoma of stomach	NO	YES	Pain	02/02/2000	Records incomplete	13/02/2000	30	4		NO	NO	
Thurston	Ethel Edith	18/03/1921	29/06/1999	26/07/1999	78	1(a) Bronchopneumonia 2 Senile dementia	NO	YES	None stated	26/07/1999	90	26/07/1999	90	1	YES	NO	YES	YES
Tiller	Sylvia	06/10/1914	04/12/1995	13/12/1995	81	1(a) Congestive cardiac failure 1(b) Myocardial infarction	YES	YES	Chest pain	12/12/1995	30	13/12/1995	30	1	YES	YES	NO	YES
Tilley	Kathleen	17/05/1918		19/10/1995	77	1(a) Congestive cardiac failure 1(b) Cor pulmonale		NO								NO	NO	
Town	Christina	30/05/1902	31/05/1996	28/11/1996	94	1(a) Bronchopneumonia	NO	NO							NO	NO	NO	
Townsend	Norman Stanley	13/06/1916	21/09/1999	25/11/1999	83	1(a) Acute bowel infarction 1(b) Peripheral vascular disease	NO	YES	None stated	22/11/1999	150	24/11/1999	260	3	YES	YES	YES	YES
Walsh	Frank	22/11/1910	09/06/1994	14/06/1994	83	1(a) Cerebrovascular accident 1(b) Cerebrovascular atherosclerosis	NO	NO								NO	NO	
Wellstead	Walter	21/03/1916	07/04/1998	13/05/1998	82	1(a) Dementia	NO	YES	Pain	06/05/1998	15	12/05/1998	30	7	YES	NO	NO	YES
Whitaker	Nellie Alice	31/03/1910		13/06/2002	92	Record not found												
Wilkie	Alice	02/09/1916	06/08/1998	21/08/1998	81	1(a) Bronchopneumonia 2 Senile dementia	NO	YES	None stated	20/08/1998	30	21/08/1998	30	2	YES	YES	NO	YES
Willcocks	Doris Winnifred	06/07/1906		xx/01/1994		Record not found												
Williamson	Ivy Kathleen	25/07/1922	21/08/2000	01/09/2000	78	1(a) Metastatic malignant melanoma	YES	YES	Distress	01/09/2000	10	01/09/2000	10	1	YES	YES	NO	
Williamson	Jack	04/07/1919	29/08/2000	18/09/2000	81	1(a) Congestive cardiac failure 1(b) Ischaemic heart disease	NO	YES	None stated	18/09/2000	Records incomplete	18/09/2000		1	NO	NO	NO	
Wilson	Robert	08/03/1923	14/10/1998	18/10/1998	75	1(a) Congestive cardiac failure 1(b) Renal failure 2 Liver failure	NO	YES	Pain	16/10/1998	20	18/10/1998	60	3	YES	YES	NO	YES
Windsor	Norma	07/05/1931	27/04/2000	07/05/2000	68	1(a) Cardiogenic shock 1(b) Ischaemic heart disease 2 Chronic lymphocytic leukaemia	NO	NO							NO	NO	NO	
Woolley	Dennis John	21/05/1928	05/12/1996	17/12/1996	68	1(a) Cerebrovascular accident	NO	NO							YES	NO	NO	
Patient A						1(a) Old age	NO	YES	None stated	09/05/1998	40	09/05/1998	40	1	YES	YES	NO	YES
Patient B						1(a) Bronchopneumonia 2 Cerebrovascular accident	NO	YES	Pain	02/08/1997	40	02/08/1997	40	<1	YES	YES	NO	YES
Patient C						1(a) Myocardial infarction 2 Multiple sclerosis	NO	YES	Pain, but not severe	11/07/1997	60	08/10/1997	250	Intermittent over prolonged period	YES	YES	YES	
Patient D						1(a) Bronchopneumonia	NO	YES	Pain	18/03/1999	20	22/03/1999	30	4	YES	NO	NO	YES
Patient E						1(a) Cerebrovascular accident 2 Carcinoma of bladder	NO	YES	Uncomfortable	Records incomplete	40	02/10/1995	80	2	Records incomplete	Records incomplete	Records incomplete	

Patient information						Further information		Diamorphine							Midazolam	Hyoscine	Fentanyl	
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Patient F						1(a) Septicaemia	NO	YES	Pain	18/07/1998	20	20/07/1998	60	3	YES	YES	NO	YES
Patient G						1(a) Carcinomatosis 1(b) Carcinoma of bladder	NO	YES	None stated	08/09/1999	50	08/09/1999	50	<1	YES	YES	NO	YES
Patient H						1(a) Congestive cardiac failure 1(b) Ischaemic heart disease 1(c) Myocardial infarction	NO	YES	None stated	16/08/1999	20	16/08/1999	20	<1	YES	NO	NO	
Patient I						1(a) Carcinomatosis 1(b) Carcinoma sigmoid colon 2 Multi infarct dementia and chronic renal failure	NO	YES	No clear reason		Records incomplete				YES	NO	NO	
Patient J						Record not found	NO	NO							NO	NO	NO	
Patient K						1(a) Carcinoma of the prostate 2 Congestive cardiac failure												
Patient L						1(a) Cerebrovascular accident	NO	YES	Agitation and distress	24/09/1998	80	25/09/1998	80	<1	YES	YES	NO	YES
Patient M						1(a) Bronchopneumonia	NO	YES	Pain (once) and deterioration	03/12/1999	20	04/12/1999	20	<1	YES	YES	NO	YES
Patient N						1(a) Bronchopneumonia												
Patient O						1(a) Bronchopneumonia		YES	Cold and uncomfortable on being moved	04/04/1999	20	08/04/1999	40	5	YES	YES	NO	YES
Patient P						1(a) Bronchopneumonia 1(b) Cerebrovascular accident 2 Senile dementia	NO	YES	Restless, pain on being moved	24/09/1996	40	01/10/1996	80	7	YES	YES	YES	YES
Patient Q						1(a) Myocardial infarction 2 Chronic obstructive pulmonary disease	NO	NO							NO	NO	NO	
Patient R						1(a) Bronchopneumonia	NO	NO								NO	NO	
Patient S						1(a) Bronchopneumonia 2 Senile dementia	NO	YES	Pain	23/11/1998	20	03/12/1998	40	12	YES	YES	NO	YES
Patient T						1(a) Bronchopneumonia		Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	Records incomplete	
Patient U						1(a) Cerebrovascular arteriosclerosis		NO								NO	NO	
Patient V						1(a) Bronchopneumonia 1(b) Chronic obstructive airways disease	NO	NO								NO	NO	
Patient W						1(a) Rheumatoid arthritis												
Patient X						1(a) Cardiac failure 1(b) Electrolyte imbalance due to persistent diarrhoea 2 Diabetes mellitus	NO	NO								NO	NO	NO	
Patient Y						1(a) Cerebrovascular accident	NO	YES	Pain (bowel infarction)	01/02/1999	100	15/02/1999	400	15	YES	YES	YES	
Patient Z						Record not found		NO							NO	NO	NO	

Department of Health & Social Care

Learning from Gosport

The Government response to the report of the Gosport Independent Panel

Published 21 November 2018

Contents

Foreword by the Secretary of State for Health and Social Care

The Gosport Independent Panel has made us see with great clarity a terrible and shameful episode in our history. To read the Panel's report is to understand how doctors, nurses, and leaders in healthcare - those we most want and need to trust - can fall away from acceptable standards of practice, with awful consequences for patients. The report also describes with quiet anger the many struggles and frustrations of the families of those who died at Gosport. For the families, the Panel's report marks an important milestone rather than an end point and, while the Government cannot express a view about any subsequent process that may take place, we would like this response to be, in part, a tribute to the Gosport families and those who have supported them for their resilience, perseverance and courage in the face of many obstacles and delays.

The Panel's report has made us think and reflect hard in Government and the NHS and in other agencies. This response document describes our initial actions and areas where we plan to do further work. I am sure, however, that this will not be the last word on the matters raised by the Panel's report. Where we see opportunities now or in future years to act to both improve the safety of care and to honour those who were so badly let down in Gosport, we will seize them, and we will act on them.

1. Introduction

1.1 The report of the Gosport Independent Panel is shocking. It is a devastating account of failures in care and in the supervision of care. The report shows the terrible cost of those failures for those who died but also for their families who have waited far too long to understand what happened to their loved ones.

1.2 The role of the Gosport Independent Panel was to describe as clearly as possible what happened at Gosport War Memorial Hospital. They have done this with great dedication, skill and effort and, while their role was to establish the facts rather than to make recommendations for policy and practice, there are a number of messages and lessons that can be drawn from the report for Government, the NHS and others.

1.3 The purpose of this document is to capture those messages and lessons and to set out the actions to follow. The Panel report has already led to the establishment of Operation Magenta by the Eastern Police Region to assess the evidence brought to light and gathered by the Panel. It is important that we let that process run to completion without further commentary. This document is therefore about policy and system issues but it is not about individual or corporate liabilities or culpabilities.

1.4 The Panel report allows us to see the failings of care in the context of the practices and expectations of the time. Although much has changed since then, there are still lessons for today and things we need to take action to improve.

1.5 This response describes three types of action:

a. Measures already in place and established, such as the controlled drugs regime;

b. Reforms that are in place and developing, such as the measures to support whistleblowers and 'freedom to speak up'; and

c. Changes where we need to go further, such as the better alignment between types of investigation.

1.6 This response document also describes the work of a number of national organisations and services to identify and apply specific lessons from the Panel's report.

1.7 We know that for those people closest to what happened at Gosport War Memorial Hospital, questions of policy may be a distance away from what concerns them

most immediately, and that they will be very interested in the outcome of the current police assessment process, 'Operation Magenta'. We hope, however, that they and others will recognise our determination to learn all we can to prevent future failings of this kind, and to act on that learning.

2. Listening to patients, families and staff

'Over the many years during which the families have sought answers to their legitimate questions and concerns, they have been repeatedly frustrated by senior figures … The obfuscation by those in authority has often made the relatives of those who died angry and disillusioned … When relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions' - Bishop James Jones, Foreword to the Panel Report.

Key Actions

1. The Government will consider how best to strengthen protection for whistleblowers within the NHS in order to support patients, families and staff to raise concerns.

2. The Government is committed to ensuring that where staff speak up (including 'whistleblowers') their concerns are investigated; and to making it more transparent in the way individual NHS Trusts manage these cases. We will legislate, subject to Parliamentary time, to make all NHS Trusts in England publish Annual Reports on concerns of this type.

3. The National Guardian will continue to champion those who speak up through her Network of Freedom to Speak Up Guardians, and will publish an independent, annual report to be laid before Parliament to showcase best practice, hold the Government and the system to account and advocate for change.

4. The National Guardian has started to take a more active approach in looking at how organisations handle concerns raised by staff who speak up and will continue to implement its approach for staff in NHS Trusts.

5. CQC is reviewing how it assesses the statutory duty of candour.

6. We will place listening to and learning from feedback at the heart of care and improving care with a new strategy to be published this year.

Lessons and Messages from the Report

2.1 The report of the Gosport Independent Panel is a story of opportunities missed and of voices unheard. If those voices had been heard sooner, a great deal of the

harm that was suffered at Gosport War Memorial Hospital could have been avoided, and lives could have been saved.

2.2 The Panel's report also illustrates how clinical authority and a culture of hierarchy and silence was used to stifle the voices of staff and families. Nursing staff first raised concerns about the prescribing and administration of drugs in Gosport War Memorial Hospital in 1991. They were marginalised, and this was the first lost opportunity to prevent so many avoidable deaths. The report helps us to see that ignoring the voices of patients, families and staff can cost lives; and while the NHS has changed a lot since these events, that basic truth remains valid and important.

2.3 Patients, families and staff were also, as the report makes clear, frustrated and at times angered by many of the investigatory processes both within and beyond the NHS that took place during and after the events described in the report. Those in authority failed to hear them when they raised concerns about safety; and it failed to hear them when they sought answers.

2.4 The Gosport Independent Panel was commissioned by the Government in 2014 to provide the families with a better understanding of what happened to their loved ones, and of how the wider system failed to identify and deal with failings in care. It has done so with great thoroughness. The Panel was not, however, put in place until 2014 when very many years had passed since the events in Gosport, and this has added to the distress and frustration of the families.

2.5 The experience of families, patients and staff at Gosport teaches us the following:

a. The concerns of patients, their families and of staff are a vital resource in avoiding harm and improving patient safety - they must be properly valued and not be treated as a nuisance or in a defensive manner;

b. Staff who speak up and all of those raising concerns must feel safe and supported when doing so, they should have confidence their concerns will be investigated;

c. Those providing care, overseeing it, inspecting it or investigating failures in it must recognise the importance of listening carefully to and supporting people raising concerns.

Freedom to speak up and raising concerns

2.6 The importance of supporting patients, families and staff to raise concerns has been driven home in recent years by the cases of Mid Staffordshire and Morecambe Bay. While these cases occurred after Gosport, the reports into them

came before the Panel's conclusions. This means that many of the measures taken after the earlier reports are also relevant to Gosport. The appointment of a National Guardian to act as a champion for those speaking up brings a national focus to this issue; and the establishment of a network of Freedom to Speak Up Guardians means that there are local champions and agents of cultural change in place up and down the country as a result of the commitment to learn from tragedies such as Gosport. It is important to recognise that many cases where staff speak up or those involving whistleblowing can be complex and multi-faceted, which makes it all the more vital for organisations and those leading them to learn from good practice, and to remain open to the potential lessons for them and their organisation when concerns are raised.

The National Guardian has, as part of her role, the job of advising Government and holding it to account so that it continues to support those raising concerns. To further increase transparency, accountability and to promote culture change the Government has requested the National Guardian to produce an annual report to be laid before Parliament. In the year 2017-18, Freedom to Speak Up Guardians reported 7087 cases of speaking up within NHS Trusts. Of these, 32% of cases related to patient safety. Of those individuals who provided feedback, 87% reported that, given their experience , they would do so again.

2.7 Those who do Speak Up deserve our gratitude and our protection. The Government has put in place a range of protections for those staff raising concerns or 'blowing the whistle' in recent years. The Department of Health and Social Care recognises the calls that have been made by some to further strengthen the protections for those Speaking Up at the point a concern is raised or during an investigation, and to improve the ways in which the issues raised are investigated. The Government will consider how best to strengthen protection for whistleblowers within the NHS in order to support patients, families and staff to raise concerns.

2.8 We also want NHS Trusts to be more transparent about the way they manage these speaking up cases to demonstrate to their staff as well as patients and the wider public that those staff who want to highlight poor practice and are concerned about patient safety are valued and will be supported to speak up without suffering detriment. Subject to Parliamentary time, we will legislate so every NHS Trust in England is required to publish information on cases of speaking up and an overview of how the matters raised have been addressed.

A culture of candour and consent

2.9 The culture at Gosport was the opposite of candid. It was defensive, hierarchical and ignored the concerns of patients and families. The co-existence of closed cultures and poor and unsafe care is not a coincidence. Where a healthcare organisation lacks interest in the views and concerns of those it treats, it can quickly become lost in a cycle of excessive self-confidence, labelling problems as external attacks or threats rather than as learning opportunities. Even in the best organisations, there can be a strong temptation to seek to explain away failings in care rather than taking the harder but more rewarding road of looking deeply into what the causes of the problem really were.

2.10 This is why the Government, as a matter of patient safety, put in place a statutory duty of candour. This means that organisations must be candid with patients and families when things go wrong. The CQC inspects against this requirement and providers of care are expected to implement the duty of candour through staff across their organisations - including educating, training and ensuring there is a 'just culture' approach to support and challenge organisations, teams and individuals as is needed. As well as being the right thing to do for patients and families, the duty requires providers of care to take a step that is vital to learning from mistakes: being honest with those who have been harmed also compels organisations and those in charge of them to be honest with themselves.

2.11 In addition, all regulated healthcare professionals working in the United Kingdom (UK) have an individual professional duty of candour, which is a responsibility to be open and honest. This responsibility is set out in their respective professional codes of conduct.

2.12 The professional regulators have published a joint statement on the professional duty of candour, which was promoted to health professionals, students and patients. Professional regulators have also included the duty of candour in the standards and guidance that health professionals are expected to meet at all times and have worked to embed these standards and guidance in practice. The professional regulators continue to work with other regulators, employers and commissioners of services to help develop a culture in which openness and honesty are shared and acted on.

2.13 The two duties of candour are mutually reinforcing and aim to help to create a culture of candour in the NHS. We know, however, that some believe that these need to be more effective, and it is clear that much remains to be done so that the spirit as well as the letter of the duty is observed. The CQC and the Government will continue to monitor progress and encourage the NHS to go further, faster.

The CQC is currently reviewing how they regulate duty of candour in order to identify if their approach can be strengthened further.

2.14 Linked to candour is the critical matter of consent. One of the consequences of placing a clear and strong responsibility on organisations and clinicians to be open with patients and families when things go wrong is that it reinforces the need, wherever possible, to obtain clear consent from the patient, rooted in a well-structured discussion, before care or treatment are provided.

2.15 The role of the CQC as the inspector of care providers is described in more detail in chapter four, but it is important to emphasise in this chapter how important patient experience is to the work of the CQC since it was significantly reformed following the Francis report. The CQC is committed to listening and acting on experiences of care in its inspections and throughout its work. The CQC's inspection teams include 'Experts by Experience' – people who have personal experience of care and who can assess the quality of the services received from the patients and/or carers perspective. The CQC invites people to pass on concerns and feedback about individual providers either on its website, by telephone, or in writing to its National Customer Service Centre. The CQC has developed a regulatory approach to monitoring and inspecting all NHS Trusts that seeks to listen more to feedback from patients, families, carers and staff. This includes receiving information on 23,544 experiences of care directly from people through their on-line form in 2017/18 which led 562 inspections to be brought forward and 147 urgent inspections being carried out.

2.16 All whistleblowing concerns raised with the CQC are forwarded to the local inspector for consideration. This allows the CQC to spot problems or concerns in local services that it may need to act upon.

A culture that listens, learns and changes

2.17 Among the many things that went wrong at Gosport was a failure of systems and of culture. The protections against poor care that organisations should bring to bear did not work; nor did those that should have been rooted in the behaviour and professionalism of those working in and running the hospital. The systems and culture at Gosport failed to stop care from moving to an unacceptable place, leading to tragic outcomes for patients and their families.

2.18 Culture is powerful but it can also be changed by the people within it. Where organisations, leaders and individuals have a genuine commitment to listen to difficult messages and to seek out problems rather than ignoring them; and where they have an accompanying willingness to change, we have seen real improvements in care, including in the most challenged organisations.

2.19 There are a number of themes in the Panel's report that are common to other reports in recent years that have identified failures in hearing the voices of patients, staff and families:

- concerns are not treated seriously;
- the quality of investigations is patchy; and
- lessons are not consistently being learned or implemented.

2.20 For too long, these issues have been allowed to continue, with those responsible not being sufficiently challenged or held to account. This Government believes now is the time for a different approach - an approach that delivers on all feedback being taken seriously, whether that feedback:

- is prompted or unprompted;
- involves raising concerns, making complaints or Speaking Up;
- is raised by service users, their families or staff; or
- is identified independently by, for example, organisations like the Care Quality Commission, the Healthcare Safety Investigation Branch, or NHS Resolution.

2.21 This means working to ensure all care organisations encourage and welcome speaking up, whether by service users, their families or staff. And, when someone does speak up, according them respect by treating what they say seriously, investigating it appropriately, and ensuring subsequent action is taken to implement any lessons learned. The voices of patients, staff and families are a precious resource, but all too often they have been treated as a nuisance or dealt with defensively. While the NHS has made some progress in listening to these voices in recent years, we need to do more. The NHS needs organisations, cultures, clinicians and leaders that listen carefully and with an open mind because they want to learn and do not become defensive when challenged. The potential benefits to care quality from getting this right are significant: careful listening can save lives. The Department therefore plans to publish a strategy for improving the way that feedback is managed and used in the NHS later this year.

2.22 The Department has asked the National Guardian to take a more active approach in looking at how organisations are handling concerns raised by staff, and whether the National Guardian's Office might further support individual staff who speak up, and ensure their concerns are being dealt with appropriately. This will include continuing to implement the National Guardian Office's case review process in the health sector. The purpose of these case reviews is to identify any areas that do

not follow good practice in that handling, not to adjudicate on disputes or to apportion blame but, by so doing, it supports organisations to identify areas for improvement at an earlier stage, enables them to address them effectively, and provides lessons to be learnt by other organisations and the system as a whole.

2.23 We believe it important to provide greater support to those staff who do ‘Speak Up’, and we shall work with the National Guardian Office to investigate the appropriateness of engaging with ‘these cases at an earlier stage.

2.24 If someone has experienced poor care or believes that poor care is being provided, they are able to report it to the CQC. The CQC carries out regular checks on health and social care services and this information helps it to decide when, where and what to inspect, including undertaking unplanned inspections if deemed necessary. Information on concerns raised and 'whistleblowing' is made publicly available in the CQC monthly Board’s quarterly Performance Reports, available online.

Putting families first when things go wrong

2.25 The case of Gosport has illustrated how all public agencies, within the NHS but also the police and other criminal justice agencies need to do more to ensure that when there are serious failings in care, families are properly engaged and understand what is happening.

2.26 The Government has also recently (in September 2018) published a victims' strategy, and the measures set out in this strategy will also serve to address some of the issues that have affected the Gosport families.

3. Ensuring care is safe

From: Summary and conclusions- Report of the Gosport Independent Panel, p316

'…during the period between 1989 and 2000 at Gosport War Memorial Hospital…There was a disregard for human life and a culture of shortening the lives of a large number of patients. There was an institutionalised regime of prescribing and administering "dangerous doses" of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff'.

Key Actions

1. NHS England review this year on the Controlled Drug Accountable Officer role, local reflection on the Panel Report, and on anticipatory prescribing.

2. Continued implementation of and support for the Learning from Deaths programme, and of the commitment to put Medical Examiners in place for non-coronial deaths.

3. A new Patient Safety strategy this Autumn to make it easier for staff to report risks and for action to be taken.

Lessons and Messages from the Report

3.1 As the report of the Panel shows, the care for many patients at Gosport War Memorial Hospital was not safe. The Panel has found that 'records show that 456 patients died where medication - opioids - had been prescribed and administered without appropriate clinical justification'. While it would be wrong to draw any conclusions about responsibility or liability at this stage given that there is an active police assessment of these issues currently underway, it is clear that the care provided at Gosport was, for a number of patients, not safe and that this was caused by a number of factors. Beyond the specific issues about the prescription and administration of opioids set out in chapter two of the report, chapter three makes clear that there was also a number of failings in the standards of care that are 'disquieting when assessed against the standards prevailing at the time'.

3.2 There are two important messages for patient safety from the report. First, the management of the prescribing, dispensing, administration and monitoring of powerful drugs is a central component of patient safety. Second, while it is vital we get the technical and regulatory defences against unsafe care right (and there will be more on these mechanisms in the following chapter) we know that it is the

norms, professionalism and willingness of clinicians and managers to stand up for safety along with the support of their organisations that will make the biggest difference to safety in the long term.

3.3 This chapter sets out what has changed and what remains to be done on controlled drugs specifically and on medication safety more widely. It also sets out what the NHS and the Government is doing to ensure a culture of safety takes root in our hospitals and other care settings. Patient safety is not a technical problem that can be fixed once and for all - it is a continual challenge, and there is always room for improvement and a constant need to manage the risks of clinical care. The governance and oversight of care within a hospital is the most important line of defence against failures in care. While there is always a need for external challenge and support (the subject of the next chapter) it is important that we continue to recognise that the safest organisations are those which take safety seriously and manage it for themselves, not those which need to be externally directed or regulated.

Controlled drugs and medication safety

3.4 The poor use of controlled drugs at Gosport War Memorial Hospital was central to the failures in care that led to the terrible consequences described in the Panel's report. Since the period analysed by the report there have been significant changes in the governance arrangements for the use and management of controlled drugs.

3.5 Many of these changes were instigated as part of the Government's response to the Shipman Inquiry's Fourth Report. The Controlled Drugs (Supervision of Management and Use) Regulations 2006 (the 2006 Controlled Drugs Regulations) (as amended) mandate health care organisations to put in place standard operating procedures on the prescribing, supply and administration of controlled drugs and the clinical monitoring of patients.

3.6 Tighter controls were also put in place by the Home Office through Regulations covering prescribing, record keeping and safe custody of controlled drugs. The 2006 Controlled Drugs Regulations also require the appointment of a Controlled Drug Accountable Officer. This Officer has statutory responsibility for the safe management and use of controlled drugs within their organisation. These Officers are required to work with healthcare providers, regulators and enforcement authorities through local intelligence networks to share any concerns about the use and management of controlled drugs.

3.7 The Regulations also require the operation of a Local Intelligence Network where concerns about systems and / or individuals can be raised. This also links to the Responsible Officers for doctors' performance.

3.8 The Care Quality Commission (CQC) ensures that health and adult social care providers maintain a safe environment for the management of controlled drugs in England. They report their findings through individual local inspection reports and by means of published annual updates to Government. The National Institute for Health and Care Excellence (NICE) produced guidance in 2016 on the safe use and management of controlled drugs. This guidance aims to reduce the safety risks associated with controlled drugs by ensuring that robust governance processes are in place and that working practices comply with legislation.

3.9 While no system can ever completely prevent the mismanagement or misuse of controlled drugs, the measures that have been put in place mean that the inappropriate use of opioids and other controlled drugs can be detected more quickly and stopped, so that protracted poor practice is less likely to continue unchecked.

3.10 In addition to specific measures on controlled drugs, the NHS has taken important steps towards improving the safety of medication more generally. The chief pharmacist role, following the report 'Pharmacy in England' (2008) was identified as the organisational lead for medicines safety, and a Patient Safety Alert in 2014 required all organisations to identify the role of Medicines Safety Officer to coordinate local medicines safety processes and work collaboratively nationally; NHS Improvement and the MHRA jointly support a network of Medication Safety Officers and Medical Device Safety Officers. As part of the Government's response to the World Health Organisation's patient safety challenge on medicines safety, we are developing a programme of work led by NHS Improvement to improve medicines safety. Work is already underway to accelerate the roll-out of electronic prescribing and medicines administration, and to deploy more clinical pharmacists in primary care and care homes. We have also introduced monitoring of the highest risk prescribing practice linked to hospital admissions.

3.11 In addition, and following on from the publication of the Panel's report, NHS England has initiated the following actions, all of which are due to be completed by the end of the year:

- A review of the governance and leadership of the Controlled Drug Accountable Officer role in NHS England;
- A review of the operation of the lead Controlled Drug Accountable Officers in NHS England, including the effectiveness of Local Intelligence Networks;

- An assurance process to assess how 'Designated Bodies' (which include NHS Trusts and Foundation Trusts) are reflecting on the learning from the report and reviewing arrangements in their organisation in the light of it.

- An assurance process focused on the appropriateness of anticipatory prescribing guidelines and that they are being followed.

A culture of safety – learning, staff engagement and continuous improvement

3.12 The Panel's report shows that along with a number of unsafe practices, Gosport War Memorial Hospital also had a culture which did not create the right conditions for safe care. In part this flowed from an environment that made it difficult for staff, patients and families to question and to challenge decisions about care which were discussed in the previous chapter. The problems at Gosport also stemmed from a lack of oversight of quality and clinical governance within the hospital and the wider health system at the time.

3.13 While it would be wrong to assume that today's healthcare system is entirely free of these problems, it is true that significant progress has been made in placing the quality of care and the importance of safety higher up the agenda for providers and others in the system, and that this has made a real difference for patients.

3.14 Recent years have seen a great deal of work on quality of care in particular patient safety in the NHS. Each of these waves of reform have emphasised the importance of both clinical and managerial involvement in care quality throughout provider organisations. Changes have centred on learning, staff engagement and continuous improvement.

Learning

3.15 To start with learning, we know that gathering data is only part of what is needed: we are also taking action to ensure that there is careful analysis and pattern-recognition that then leads to action. The Learning from Deaths programme embodies a standardised and systematic approach to examining the care provided to people who die in order to identify improvements for future patients. This will be an important supporting mechanism for the development of Medical Examiners, a critical reform to ensure that patterns in non-coronial deaths are picked up and acted upon. Trusts have each published a policy on how they respond to and learn from deaths. Trusts are also required to review and publish locally the numbers of deaths thought to be due to problems in care on a quarterly basis, and evidence of what they have learned and the actions taken to prevent such deaths in future on

an annual basis. This new level of transparency is fundamental to a culture of learning and ensuring the safety of NHS services. The CQC has strengthened its assessment of Trusts' learning from deaths as part of its annual inspections of Trusts. CQC's approach to inspection will include monitoring implementation of new guidance for Trusts on working with bereaved families and carers published in July. In June, we announced that primary care and ambulance Trusts will be the next focus for reviewing deaths to help understand and tackle patient safety issues. By looking at how to extend the learning from deaths policy to GPs and ambulance Trusts, more parts of the NHS will be made safer by generating learning and enabling local health organisations to learn from one another.

3.16 A range of other data related to safety and quality, including the Friends and Family Test which gives patients the opportunity to feedback to providers of NHS funded care or treatment, are also published on a regular basis. Quality accounts, published annually by each provider, including the independent sector provide transparency about the quality of their services by reporting on patient safety, the effectiveness of care and patient feedback about the care provider. All of this helps Trusts and Foundation Trusts and their regulators build up a picture of the quality of care and of how the safety of services can be improved.

Staff engagement

3.17 Learning must be supplemented with action based on the recognition that it is staff who make all the difference in patient safety. We have therefore supported national efforts to encourage positive changes in culture. Sign up to Safety was launched in June 2014 to strengthen patient safety in the NHS. The campaign aims to help member organisations listen to patients, carers and staff, learn from what they say when things go wrong and act to improve the safety of care. Since 2017 the campaign has focused upon communication as key to improving patient safety.

Continuous improvement

3.18 Finally, along with measurement, we need governance and an inquisitive and programmatic approach. The Patient Safety Collaborative (PSC) is a joint initiative, funded and nationally co-ordinated by NHS Improvement, with the 15 regional PSCs organised and delivered locally by the Academic and Health Science Networks. The programme has both identified priorities for health improvement that will make a difference to local healthcare systems as well as define good clinical practice for national priorities. The PSC will continue to provide the capability and capacity needed to support both local and national safety improvement programmes.

3.19 These features of a safety culture are profoundly linked to the need for candour, openness and willingness to learn set out in the previous chapter. Without a commitment to learn, gathering information about what can go wrong will not change care; conversely, without measurement and governance to identify issues and drive change, the willingness to do something to make care safer may not resolve itself into clear action. Both are needed.

Further action

3.20 The Government and the NHS are committed to continuing to find new ways to promote and improve patient safety. NHS Improvement has developed and published a Just Culture Guide endorsed and supported by Royal Colleges, patient organisations, unions, and professional regulators. The guide supports managers to understand when an individual member of healthcare staff needs personally targeted support or intervention to work safely, and when there are wider issues with safety systems that require action.

3.21 Dr Aidan Fowler has recently been appointed as the new NHS National Director of Patient Safety and his appointment provides an opportunity to provide new leadership to this agenda across the system. Dr Fowler has also been appointed as a Deputy Chief Medical Officer and will provide advice to the Department of Health and Social Care in this capacity.

3.22 Dr Fowler will develop a new Patient Safety Strategy with proposals to be published in the Autumn alongside the long-term plan for the NHS. The strategy is aimed at ensuring the NHS is the safest healthcare system in the world and includes proposals for making it easier for frontline staff to report incidents and improving the way the NHS acts on patient safety risks. This work is underpinned by the principles of openness and transparency, considering how to support further development of a just safety culture in the NHS, and ensuring a focus on continuous learning and improvement. It is important that the development of this strategy takes account of what patients, clinicians, managers, healthcare providers, and other stakeholders think and so Dr Fowler will be presenting his ideas and inviting others' thoughts on how the NHS can deliver these aims. Once defined however, this work will become the blueprint for safety in the NHS, building on the legacy of 'An Organisation With a Memory', the Berwick Report 'A Promise to Learn – a commitment to act' and indeed the findings of the Gosport Inquiry.

3.23 Finally, a culture of safety is one that recognises, values and empowers the staff who make care safe for patients day in and day out. To help support this, a new national role of NHS Chief People Officer has been created and the recruitment process for this role is underway. This position will have responsibility for ensuring

that the NHS has a cohesive and deliverable people strategy reflecting strong values and championing people in the NHS.

Isolated Practice

3.24 One of the features of the care provided at Gosport War Memorial Hospital that the Panel's report brings out very vividly is the relative isolation of the organisation and of the staff who worked there. While there were some connections with the wider system, there is a strong sense from the report of a group of clinicians and an organisation that had become cut off from the norms and expectations that were in place elsewhere.

3.25 Isolated practice is not simply determined by geography, organisational structures or by the size of an organisation, but these factors seem likely to play a part in increasing the risk of such practice taking root. Isolated practice is also not necessarily a direct cause of poor care, though, again, it seems likely to be a risk factor for it. One of the lessons of the Panel's report and of a number of other reports (including the experience of a number of providers that have been through the Special Measures) is that the quality of care is in part dependent upon the strength of connections within and beyond the organisation and that poor care thrives where connections are weak. This is why the use of peer support or 'buddying' has been an important factor in helping providers in Special Measures to navigate their way back to an improved position. It is also why providers themselves, along with those inspecting and regulating them need to be alive to the potential risks of isolated practice as they do their work.

Syringe Drivers

3.26 Following the publication of the report of the Panel, there were a number of media reports referring to the use of syringe drivers. These devices are used to deliver a continuous, steady dose of pain-relieving medication. When used safely they can be highly beneficial to patients. Syringe drivers were used at Gosport War Memorial Hospital, and the report mentions them on a number of occasions. As the chair of the Panel, Bishop James Jones stated in a letter to the Sunday Times after the report of the Panel was published that 'The four clinicians [on the panel] and the whole panel were unanimous that syringe drivers were not responsible for the overprescription that led to the shortening of 456 lives'. Following the media reports, the Department of Health and Social Care has reviewed the evidence about syringe drivers, looking in particular at the patient safety alert that was issued in 2010 by the National Patient Safety Agency and subsequent action to implement it. This safety alert instructed providers to put in place a transition to new models of syringe drivers which had better safety features than those widely

available up to that point. In the Summer, NHS Improvement undertook a survey to assess whether any of the older model of syringe drivers remained in use. They found no evidence of their continued use, with the one exception of a patient using the driver to self-administer drugs at home for a long- term condition (they have now switched to a more modern device). While the Department's review of evidence did not establish any cause for concern about the 2010 alert or its implementation, it is undertaking further work with the NHS Improvement Patient Safety Team and the Medicines and Healthcare Products Regulatory Authority to assess what improvements could be made to ensure that safety issues linked to the design of medical devices or to the availability of safer alternatives are recognised and managed as effectively as possible.

Conclusion

3.27 Keeping patients safe requires a team effort. It needs us all to play our part and to support others in making care safer. It involves recognition of the human as well as the technical factors which can make all the difference. It requires speaking up and being heard, and it relies on commitment and vigilance at all levels of an organisation providing healthcare. While inspection and regulation are vital in identifying and addressing cases of poor or unsafe care, the best means of prevention lie in the hands of healthcare organisations and the people working in them. We will continue to be committed to supporting them to do all they can to learn from recent and less recent problems, and to continue to build a culture of safety.

4. Identifying and addressing problems in care

'The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.' - Panel report, p316.

Key Actions:

1. CQC review of its external oversight in the light of the Panel report, including looking at responding to feedback, its assessment of medicines management (including controlled drugs) and working with partners on prescribing issues.

2. As NHS England and NHS Improvement work more closely together, they are putting joint oversight of the quality of care at the heart of their new structures.

3. Government commitment to bring forward proposals to reform the framework for professional regulation.

4. GMC commitments to introduce a senior patient champion; and to review the relationship between its processes and those of the police.

5. NMC commitments to accelerate the introduction of its Public Support Service; and work with nurses to identify the key learning from the Panel report for the profession.

6. General Pharmaceutical Council commitment to work with the pharmacy representative bodies to develop a framework for pharmacy to assess what changes have already been made to help prevent a similar situation to that described in the Panel report happening again and encourage discussion across pharmacy on any further actions that could be taken.

7. Appointment of a National Medical Examiner to provide professional and strategic leadership and set quality standards for Medical Examiners.

8. Revision of the NHS Serious Incident Framework.

9. The Government will explore what more can be done to ensure that investigatory processes relating to serious concerns (whether on an organisational or individual

level) relating to healthcare are organised so that they both are fully compliant with the relevant statutory remits and the interests of justice while also recognising and addressing the concerns and priorities of patients and their families.

10. The Ministry of Justice will refresh its Guide to Coroner Services to make it better tailored to the needs of bereaved families.

11. The Government has committed to establish an Independent Public Advocate and published its consultation on the role on 10 September 2018.

Lessons and Messages from the Report

4.1 The Gosport families waited far too long for the answers and evidence set out by the Independent Panel. The different attempts to find answers undertaken by healthcare bodies, regulators the police and the coronial service, were unable to bring a full and clear picture of events to light. In addition, these different processes did not always interact well with one another, adding to the frustration and concern of the families.

4.2 The regulation and oversight of healthcare will always be required. This applies to both individual clinicians and to organisations. The combination of power, vulnerability and complexity as inherent, intertwined features of healthcare means that it is highly unlikely that leaving providers of care to manage all of these factors themselves would ensure safety and quality of care. Striking the right balance between self-improvement and external oversight and intervention is a perennial challenge for all healthcare systems. The best forms of regulation, oversight and intervention provide insight and support to allow healthcare organisations to learn and improve for themselves, even if that is not an immediate possibility.

4.3 At times it is necessary to go beyond regulation and oversight to investigate the conduct of individuals or organisations. The report of the Panel looks in detail at a number of investigatory processes that were undertaken in response to the events at Gosport War Memorial Hospital, and points to a number of shortcomings in many of these processes.

Identifying and addressing problems - inspection and improvement

4.4 The current system of inspection and provider oversight was not in place when the events described by the Panel's report took place. While there can never be an absolute guarantee that any such system will prevent failures in care, it is highly

likely that the current system of independent, clinically-led inspection and risk-based support, improvement and intervention would have been able to identify and address the issues described in the report at an earlier stage.

4.5 Inspection, regulation and oversight form part of the culture of the healthcare system. In the years following the publication of the Francis report into Mid-Staffordshire NHS Foundation Trust, these functions have been significantly reshaped to both foster improvement within providers but also to act as a 'critical friend' to them, telling hard truths when necessary and acting to intervene when the safety and interests of patients require it.

4.6 One example of this is the Special Measures regime for quality established following the Keogh Review into avoidable mortality in 2013. This ensures that Trusts where serious care quality failings have been identified by the CQC and where their leadership is unable to resolve the problems receive increased oversight and intensive support from NHS Improvement to help them turn around the quality of their care. NHS Improvement has built on this model to enable it to provide early intervention where it is needed, putting in place processes to identify 'challenged providers' with the potential to enter special measures ensuring early support is in place for these organisations. The progress of providers in special measures and of challenged providers is reviewed through a joint governance mechanism with other oversight bodies and regulators.

4.7 The CQC's inspection model has been shaped by the learning from failures in care from investigations and reviews such as Mid Staffordshire NHS Hospital, Winterbourne View, Morecambe Bay and Southern Health. In response, the CQC developed a regulatory approach to undertake comprehensive inspections of all NHS Trusts that sought to listen more to feedback from patients, families, carers and staff. The approach is structured around five key questions that are asked of all care services:

i. Are they safe?

ii. Are they effective?

iii. Are they caring?

iv. Are the responsive to people’s needs?

v. Are they well-led?

4.8 Having established baseline ratings of all NHS Trusts, starting in 2013, a more responsive approach to regulation was introduced for NHS Trusts in June 2017. A key element of the new approach is more use of wider intelligence as part of

monitoring and inspection. CQC's inspection teams have relevant expertise in the care sectors they inspect. This includes assessing the management of medicines, including controlled drugs. CQC has powers to take enforcement action when necessary, to ensure breaches of regulations are dealt with in a timely and proportionate way.

4.9 The CQC is undertaking a review of its external oversight in light of the Panel's report. This will include looking at issues such as how it listens and acts upon feedback from patients, families, carers and staff; the governance and oversight of doctors in community services; how the CQC assesses the management of medicines, including controlled drugs such as opioids; and how CQC works with partner organisations such as NHS England in sharing information and intelligence.

Working together for safety

4.10 The cases of Gosport, Mid Staffordshire and other failures in care have reinforced the need for national and regional oversight bodies to work closely together to share intelligence and insight. New forums and mechanisms, such as the Joint Strategic Oversight Group (JSOG), have been established to share intelligence, develop aligned approaches to support Trusts and exchange learning across the system. The JSOG currently operates at national level and consists of a group of senior representatives from NHS Improvement, NHS England, CQC, HEE and GMC who meet bi-monthly.

4.11 The new operating model being developed between NHS Improvement and NHS England is building in alignment of national and regional oversight and support, through a consistent structure at senior level across regions and across the national medical and nursing teams, and senior leadership accountable to both organisations. These new arrangements are intended strengthen the way the two organisations work together to oversee and support providers, including further improving intelligence sharing, identification of risks and co-ordinated support interventions.

4.12 NHS Improvement has been developing approaches to better use available resources in its central and regional teams, to ensure it reflects priorities and support needs across the country an example of this is the piece of work undertaken by NHS Improvement to identify risk in the provider sector. The Executive Medical Director and Executive Director of Nursing have conducted an organisation-by-organisation review using a broad range of information and metrics to identify if there are any early signals that quality is at risk.

4.13 NHS Improvement, working with other national organisation, plans to run regional exercises to stress test the approach to oversight. The purpose of these exercises will be to consider the following questions:

a. What should we collectively have spotted earlier, and what would need to change to make sure that we do next time?

b. What additional information or intelligence would make it more likely that concerns are identified early in future?

Identifying and addressing problems - professional regulation

4.14 The system of professional regulation has changed significantly since the events described in the Panel report. Professional regulation has been reformed to make it more independent from both the professionals they regulate and from Government. The four United Kingdom (UK) governments consulted in 2017-18 on high-level principles for reform to ensure professional regulation is proportionate, more consistent, less costly and better supports the development of a flexible workforce.

4.15 The five aims set out in the consultation were to:

- support the development of a flexible workforce that is better able to meet the challenges of delivering healthcare in the future;
- improve the protection of the public from poor professional practice;
- deal with concerns about the performance of professionals in a more proportionate and responsive fashion;
- provide support to regulated professionals in delivering high quality care; and
- increase the efficiency of the system.

4.16 The Government recognises that the current framework for the regulation of healthcare professionals is prescriptive, inconsistent and bureaucratic and does not support the development of a modern, flexible workforce. Officials are analysing the responses and the Government will be setting out its proposals to take this work forward shortly.

4.17 In addition to this work to reform the system of professional regulation as a whole, the regulators themselves have been reflecting on the Panel's report to assess the

lessons to be learned and how other reforms in recent years have added to the system's resilience.

General Medical Council

4.18 A number of changes have been made to the General Medical Council's (GMC) legislative framework to increase the transparency, accountability and efficacy of the GMC's processes. These are set out below.

4.19 The GMC council which registers and regulates doctors has reduced from 104 registrant members in 2003 to 12 members now, split 50/50 between lay and registrant members, with the latter being appointed by the Privy Council rather than being elected by other registrants. This increases the GMC's independence from the profession that it regulates.

4.20 The Medical Practitioners Tribunal Service has been established to undertake fitness to practise adjudication for doctors. This provides for greater independence of decision-making.

4.21 Finally, in December 2012 the GMC introduced an ongoing system of revalidation to ensure that doctors remain up to date and fit to practise. As part of this, all licensed doctors must have an annual appraisal and collect, reflect and act on feedback from patients and their colleagues, as well as complaints about their practice.

4.22 In recent years, the GMC has made substantial changes to how it works with families, patients and witnesses that engage with their processes. For example, the GMC's Patient Liaison Service set up in 2015 invites complainants to discuss the GMC's processes and answer any questions that they may have so that they are involved in the investigation process. Having reflected on the Panel's criticisms, the GMC has decided to also introduce a patient champion role at a senior level at the GMC to improve further how they listen to and engage with the voices of patients, families and friends, and the wider public.

4.23 It is much easier for the GMC to ensure timely disclosure of any documentation or material deemed necessary for a fitness to practise investigation. These powers allow them to require any person who is able to supply information or produce a document that appears relevant to their enquiries to provide that information[1]. Having reflected on the Panel's criticisms of how they interacted with the Police,

[1] The Williams Review into Gross Negligence Manslaughter in Healthcare recommended that the GMC's power to require information from registrants exclude records of reflective practise. The Government accepted all recommendations.

the GMC is reviewing its investigations processes where there is an ongoing police investigation to identify any changes they need to make to guidance for staff and decision makers and any other further improvements they can make. This will ensure they are doing everything they can to progress such investigations in a timely fashion and ensure that they can take action in a timely way where patients may be at risk. They will reflect with other regulators on any further lessons that can be learned as a result of events at Gosport War Memorial Hospital.

4.24 The GMC is also committed to working closely with other professional and systems regulators across the UK to ensure any improvements to information sharing protocols or other processes are implemented in a timely fashion.

Nursing and Midwifery Council

4.25 The Nursing and Midwifery Council (NMC) has changed significantly since the events described in the Panel report. The NMC has issued a new Code which sets very clear professional standards of practice and behaviour for nurses and midwives. A new system of nurse revalidation means that all nurses and midwives regularly have to demonstrate they are practising safely and effectively in line with the Code. The NMC has also published guidance to help nurses and midwives know when and how to raise concerns and what their professional duty of candour is when things go wrong.

4.26 The NMC has affirmed its commitment to improving the way it engages with and supports patients, service-users, and family members who raise concerns about nurses and midwives. It has set up a public support service to ensure that concerns raised by patients, service-users and family members are properly listened to and acted upon. It now also provides specialist support and help to patients, service-user, and families throughout the fitness to practise process.

4.27 The NMC has put in place measures to support it to protect the public more quickly and effectively. The NMC has significantly changed the way it works with employers to help them to identify risks and make sure they are supported to make appropriate referrals to the NMC at the right time. The NMC has also worked to improve its investigation processes and the time it takes to conclude fitness to practise proceedings has significantly reduced: more than 80% of cases are now resolved in 15 months. The NMC works closely with other regulators to share information and intelligence and make sure that risks are identified and resolved by the right organisations.

4.28 Following a public consultation, the NMC has recently launched a new approach to fitness to practise which aims to foster a culture of openness and learning in the health and social care sector.

4.29 The NMC is also, in the light of the Panel report, working to accelerate the introduction of its Public Support Service, which will put patients, families, carers and the public at the heart of their work, supporting people involved in their cases so that they are held as important partners through the process. The NMC has also committed to working with a group of nurses to review the Panel's report to identify the key learning for the profession.

General Pharmaceutical Council

4.30 The General Pharmaceutical Council (GPhC) was established in 2010 as the regulator for pharmacists, pharmacy technicians and pharmacy premises. The GPhC replaced the Royal Pharmaceutical Society of Great Britain, which had been both the professional and regulatory body for pharmacists. The GPhC works to assure and improve standards of care for people using pharmacy services, including through the investigation of concerns about pharmacy professionals and the inspection of registered pharmacy premises.

4.31 The GPhC has introduced a system of revalidation to provide greater assurance to patients that the health professionals they register remain up to date and fit to practise. These revalidation processes include requirements such as peer discussion, which is designed to encourage professionals to engage with others in their reflection on learning and practice and help reduce the potential for professional isolation.

4.32 The General Pharmaceutical Council has also been reflecting on the Panel's report and considering action in response. In July 2018, the GPhC reported on the work undertaken in response to the Panel report to its governing council at a public meeting. This discussion affirmed the importance of individual pharmacists to speak up when they have concerns, and the responsibility of pharmacy owners to create an environment in which their professional staff can meet the relevant standards. Further work is now underway to develop a framework to review all current pharmacy arrangements to prevent a similar situation to that described in the Panel report happening again, and to identify any necessary actions. The General Pharmaceutical Council is committed to work with the pharmacy representative bodies to develop a framework for pharmacy to assess what changes have already been made to help prevent a similar situation to that described in the Panel report happening again and encourage discussion across pharmacy on any further actions that could be taken.

Medical Examiners

4.33 One of the critical failings identified by the Panel's report was the failure of the hospital or the wider NHS to look at individual deaths or patterns of deaths to see whether there was learning, improvement or intervention required in response.

4.34 In addition to the work on learning from deaths described in the previous chapter, from April 2019 we will be introducing Medical Examiners to scrutinise all non-coronial deaths. Medical Examiners will provide a service to the bereaved, increasing transparency and offering them the opportunity to raise concerns. Medical Examiners will provide a new level of scrutiny to help deter criminal activity and poor practice. Medical Examiners will also report matters of a clinical governance nature which will support local learning and help to determine changes to practice and procedures. Once fully in place, the system will ensure that every death is scrutinised, either by a coroner or a medical examiner, so that any clinical issues and learning can quickly be identified, improving patient safety and informing targeted learning from deaths initiatives.

4.35 The system will have an independence, overseen by a National Medical Examiner, providing leadership to the system. The National Medical Examiner will provide professional and strategic leadership and set quality standards for Medical Examiners. Pilots of the Medical Examiner process, across a range of localities across England and Wales, have demonstrated that the process works efficiently and effectively, and is a crucial enabler for learning from deaths. The introduction of Medical Examiners will be achieved without imposing undue delays impacting on the bereaved or undue burdens on medical practitioners and the wider system.

4.36 A digital solution will be developed to ensure consistency of approach and a record of scrutiny by medical examiners. Training in the form of E-learning relating to the non-statutory medical examiner system has been developed. More details relating to the medical examiner system can be found on the Royal College of Pathologists website.

Healthcare Investigations

4.37 The case of Gosport, along with a number of other failings in care in recent years have highlighted the need for improved healthcare investigations in the interest of organisational and system learning This is something that the Government remains committed to improving.

4.38 The NHS Serious Incident Framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents

happening again. Following an engagement exercise during summer 2018, the framework is currently being revised.

4.39 In 2016, the Government established the Healthcare Safety Investigation Branch (HSIB) to conduct high level investigations into selected patient safety incidents with the sole purpose of system wide learning and improvement. By only focusing on learning and not attributing blame, HSIB fosters an open and transparent approach to its investigations that aims to support all involved in their contributions to an investigation. The HSIB has been operational since April 2017 and has commenced 12 investigations. Each investigation is providing vital learning for the NHS and system bodies. The Government has demonstrated its commitment to HSIB and its principles by publishing the draft Health Service Safety Investigations Bill, which would enable the establishment of a new, independent body, with powers to carry out its investigative functions, that will take forward the work of HSIB.

4.40 The case of Gosport has also reinforced the importance of listening to the concerns of patients and their families. The Department of Health and Social Care is considering its policy regarding historical unresolved cases in the NHS so that we can ensure that patients and families have the right platform to have their voices heard.

Police investigations, criminal justice processes, Inquests and coronial processes

4.41 While the Panel report helps us to understand the distinct rationales for the different investigations, it is also clear that the cumulative effect from the perspective of the families was of a confusing, overlapping, under-co-ordinated and, for them, ultimately unsatisfactory set of investigations and assessments of the evidence. The different agencies did not always work well together and, while it is clearly important for each to operate faithfully within their own statutory remit, the consequences for the families were often difficult for them to understand or accept.

4.42 As Chief Constable Olivia Pinkney said of Hampshire police following the publication of the report, 'The force has always acknowledged that the first two police investigations were not of a high quality. The report makes clear a view from the panel that the third did not look widely enough. We accept the panel's findings and I would like to take this opportunity to apologise for our part in the distress caused to families for so many years'.

4.43 The Panel report highlights a number of challenges for the police when seeking evidence from healthcare professionals, particularly when investigating allegations relating to medical decisions in a healthcare setting.

4.44 It is critical that the police are able to feel confident when engaging with healthcare professionals as part of criminal investigations and for both parties to have an understanding of the expectations placed on them. Where the police feel that what they are getting falls short of these expectations, they should feel comfortable to seek further input from other medical professionals where appropriate. Moreover, in cases where there are wider concerns about practices in a particular location, seeking alternative expert advice from elsewhere in the health service should always be considered be the norm. The Government will work with the National Police Chiefs Council (NPCC), Crown Prosecution Service and health authorities to better understand these challenges and to explore ways to ensure that both the police and health professionals are aware of expectations and of best practice in engagement during criminal investigations.

4.45 The Panel report also highlights a number of delays to processes caused by concern about interfering with other processes that were considered to have primacy. In addition, the audit commissioned by the Government that was produced by Dr Richard Baker was not published for ten years after it was completed. This was, as the report makes clear, on the basis of legal advice that such material should not be published while other processes were being carried out. While this was legally correct, the length of time that elapsed was considerable and compounded the suffering of the Gosport families.

4.46 There has been some progress in recent years in the co-operation and mutual understanding between the relevant investigatory and regulatory agencies. But this needs to be enhanced. The Government will explore what more can be done to ensure that the various investigations, whether on an organisational or individual level, and any associated criminal justice, or coronial processes that might follow relating to serious concerns about healthcare are appropriately sequenced or coordinated. We will look at how they can be organised so that they meet the interests of justice and are fully compliant with the relevant statutory remits; while also recognising and addressing the concerns and priorities of patients and their families.

4.47 It is clear that some people who attended the inquests into the deaths at Gosport found the process difficult and confusing. In the years since the shocking events at Gosport took place there have been important changes in the coroner system. In July 2013, we implemented reforms in the Coroners and Justice Act 2009 which changed the way coroner investigations and inquests are conducted. These reforms had the central aim of putting the needs of bereaved people at the heart of

the coroner system. Coroner services continued to be locally delivered but within a new framework of national standards to enable a more efficient system of investigations and inquests. Under the reforms, bereaved people have the right to request most of the documents seen by the court. They can expect the coroner's office to update them at regular intervals and explain each stage of the process, so that they can understand what is happening and why. And they can expect to be treated with compassion and respect.

4.48 The 2013 reforms saw the introduction of the Chief Coroner who provides leadership, guidance and support to coroners. The Chief Coroner oversees compulsory training for all coronial office holders. His annual report to the Lord Chancellor, on all inquests which take more than 12 months to complete and on other issues of note, is published in Parliament. Where a coroner has written a "report to prevent future deaths" (under Regulation 28 of the Coroners (Investigations) (Regulations) 2013) at the conclusion of an inquest, the Chief Coroner will publish it on his website together with the responses received to the report.

4.49 Much has been achieved since 2013 and there is evidence of excellent practice across the country. However, we know that there is more to be done and the Ministry of Justice is currently taking forward a number of workstreams to ensure that bereaved families are indeed at the heart of the coroner process and supported throughout.

4.50 In 2014 the Ministry of Justice published a *Guide to Coroner Services* which explained what any user of coroner services could expect from the coroner and their staff. We will be publishing a refreshed edition of the *Guide* which is specifically focused on the needs of bereaved families and which aims to answer questions they are likely to have. We are also considering other means of communication including leaflets for those attending inquests where the deceased died in state detention such a s a prison or mental hospital.

4.51 The Ministry of Justice has re-established an inquest stakeholder forum to enable key stakeholders to come together to discuss issues on coroner services. The forum met for the first time in late October. Members include government departments, the Chief Coroner's office, representatives from senior coroners and coroner officers and three important third sector organisations - Cruse Bereavement Care, the Coroners' Courts Support Service and INQUEST. The forum will help us make sure that the work we do, such as revising communications and information, meets the needs of bereaved families.

4.52 The Ministry of Justice is considering extending support services for coroner's inquests to all coroner's courts so that bereaved families have access to practical

and emotional support when they attend inquests. Currently there are support services in 43 of the 88 coroner areas.

4.53 The Ministry of Justice has been engaging with the Chief Coroner's office both on training coroners - so that they have more confidence in controlling inquest proceedings and the lawyers who attend, and in keeping questions relevant - and on training coroner's officers, to make sure that the language they use with bereaved families is always sensitive and appropriate. Linked to this, the Ministry of Justice has been discussing the conduct and training of lawyers with the professional bodies (the Bar Standards Board and the Solicitors Regulation Authority), looking at what they might do to improve lawyers' conduct in inquests where improvement is needed.

4.54 Whilst we are confident that public bodies generally instruct their lawyers to assist the coroner and are keen to learn from inquest findings, the perception of families is sometimes different. The Ministry of Justice is therefore working with other government departments to develop a protocol consisting of key principles, to which we propose public bodies and their legal representatives will sign up, as to the approach that will be taken in inquests when a public body is represented. The aim is to help make sure not only that bereaved families are really at the heart of the process, but that the process is truly inquisitorial and seeks to identify lessons to be learned. Finally, the Government remains committed to the establishment of an Independent Public Advocate to act for bereaved families after a public disaster. The IPA will support them at public inquests, ensuring their voices are heard and that they are able to fully participate. A consultation on the role is underway and will close on 3 December, with a Government response to be published next year. We would strongly encourage all those with an interest in the issues raised in this report, including those most closely affected by them, to take part in the consultation.

5. Conclusion

5.1 The profound failings in care, governance oversight and investigations identified by the report of the Gosport Independent Panel represents both a warning to all of us involved in health and care, and a serious call to action.

5.2 In addition to the actions and commitments set out in this document, it is vital that all organisations and individuals involved in the health and care system continue to reflect on the events described by the report, and do all they can to avoid such a deep failure to occur again.

5.3 Much has changed for the better in recent years, making it much harder now for practices such as those described by the Panel's report to go undetected; but we must balance that conclusion with the need to avoid complacency. The Government will therefore continue to offer support and challenge to all of those involved in health and care, from providers through to system and professional regulators, so that we can to honour those that have suffered so much by continuing to listen, learn and improve.

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Acute Care and Quality, Department of Health and Social Care.

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