Gosport

Code A

24 June 2009

Nursing & Midwifery Council
23 Portland Place
London
W1B 1PZ

Dear Sir/Madam,

**GOSPORT WAR MEMORIAL HOSPITAL (GWMH)**

My step-father, Arthur Dennis Brian CUNNINGHAM, is one of 12 patients whose untimely deaths are currently under investigation by the General Medical Council in relation to Dr Jane Barton.

Upon giving my own evidence last week, I have been permitted to observe subsequent proceedings, which involve the cross-examination of various nurses concerned with my step-father's care (still in progress). After listening to the evidence and remarks under cross-examination of Nurse Barrett, I am in a state utter disbelief that more was not done by the authorities to scrutinise and rectify the problems of the so-called caring staff at the GWMH. The questioning of Nurse Barrett was such that she had to be stopped by the Panel's legal representative from incriminating herself, which would surely have followed if she had been allowed to go on. In the endvent, she was advised that she could refuse to answer such questions, which is what she went on to do.

From the records, the care of my step-father was in the hands of Gillian Hamblin, (insert names....other names listed here) and it has been apparent for some time that they all had a hand in his demise in five days after admission for bed-sores, under the reckless prescribing of the responsible doctor, Dr Jane Barton. The consequences of Dr Barton's actions will surely be decided in the coming weeks, but nothing appears to be happening about the nurses. In all the cases I have heard so far, there can be no doubt that they exceeded their authority by commencing syringe drivers unduly, and then administered unnecessary increases of opiates until death ensued, which is what happened to my step-father. It is clear from the evidence that I heard personally only yesterday, that this was common practice in Dryad Ward at that time.

The more I hear about the events that went on at the GWMH, the more it would appear there was a one-fit terminal solution for whoever was unfortunate enough to enter Dryad Ward and, as I now know from today's evidence (Nurse Code A), Dryad Ward was NOT for rehabilitation even though the families were led to believe it was.

It is surely time for the Nursing & Midwifery Council to come out of the shadows and stand up for what is right. D~~as, d~~espite all the evidence over the years, including a damning report by the Council for Health Improvement in 2002, the Council ~~seem to have sat on its thumbs in a state of blind ignorance~~ has, so far, failed to step forward and hold the nursing staff to account for actions which led to the premature deaths of many patients.

Please would you acknowledge safe receipt of this letter and indicate the timescale within which I can expect you to return to me with details as to your proposed course of action.

I look forward to hearing from you.

Yours faithfully,

Charles Stewart-Farthing

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