OPERATION ROCHESTER

CASE SUMMARY

BACKGROUND

The Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital which is managed by the Fareham and Gosport Primary Care Trust (PCT). It was part of Portsmouth Health Care (NHS) Trust from April 1994 until April 2002, when the services were transferred to the local PCT. It is operated on a day-to-day basis by nursing and support staff, employed by the PCT. Clinical expertise is provided by way of visiting general practitioners and clinical assistants, consultant cover is provided in the same way.

Elderly patients are usually admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who, in 1988, took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

POLICE INVESTIGATIONS

Operation ROCHESTER is an investigation by Hampshire Police Major Crime Department into the deaths of a large number of elderly patients at GWMH. It was alleged that elderly patients who were admitted to the GWMH from as far back as 1989 for rehabilitative or respite care, were inappropriately administered Diamorphine by use of syringe drivers, resulting in their deaths.

Most of the allegations involve a particular General Practitioner, Doctor Jane BARTON. Death certificates of patients who died at the GWMH between 1995 and 2000 total 954, of which 456 were certified by Doctor Jane BARTON.

This matter has been investigated by Hampshire Police on three separate occasions.

First Police Investigation

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS, aged 91 years.

Mrs. RICHARDS died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. RICHARDS, two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Officers from Gosport C.I.D. carried out an investigation and in due course, a file was submitted to the Crown Prosecution Service.

In March 1999 the Reviewing CPS Lawyer gave the opinion that on the evidence available, he did not consider a criminal prosecution was justified.

On hearing of this decision, Mrs. MACKENZIE expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

A team of detectives from the Major Crime Department (Eastern) commenced the re-investigation into the death of Gladys RICHARDS on Monday 17th April, 2000.

Professor Brian LIVESLEY, who is an elected member of the Academy of Experts, provided expert medical opinion. Professor LIVESLEY provided a report dated 9th November 2000 of his findings in the case of Gladys RICHARDS. Professor LIVESLEY made the following conclusions:

- "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."

Professor LIVESLEY provided a second report dated 10th July, 2001 during which he added:

- "It is my opinion that as a result of being given these drugs, Mrs. RICHARDS death occurred earlier than it would have done from natural causes."

As a result of Professor LIVESLEY's report dated 9th November 2000, a meeting took place on 19th June, 2001 between senior police officers, the CPS caseworker Mr. Paul CLOSE, Treasury Counsel and Professor LIVESLEY. During that meeting, Treasury Counsel came to the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

In August, 2001 the Crown Prosecution Service advised that their was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Mrs. Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH. As a result of this four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors. These were Professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to the RICHARDS case and would therefore attract a similar reply. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October, 2001 the Commission for Health Improvement (CHI) launched an investigation into the management, provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible in GWMH.

A report of the findings of the CHI investigation was published in May 2002. The report concluded that a number of factors (detailed in the report) contributed to a failure of the Trust systems to ensure good quality patient care. However, the Trust now has adequate policies and guidelines in place that are being adhered to, governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer, Sir Liam DONALDSON, commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September, 2002 staff at GWMH were assembled in order to be informed of the intended audit at the hospital by Professor BAKER. Immediately after the meeting concluded, nurse Anita TUBBRITT, who had been employed at GWMH since the late 1980s, handed over to the hospital management a bundle of documents. These documents were copies of memos, letters and minutes all relating to the concerns of nursing staff which were raised at a series of meetings held in 1991 and early 1992 about the increased mortality rate of elderly patients at the hospital, the sudden introduction of syringe drivers and their use by untrained staff and the use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol). Concerns raised by nursing staff in relation to the prescribed Diamorphine involved Doctor Jane BARTON.

As a result of the disclosure of the 1991 documents the existence of the documents was reported to the police and a meeting of senior police and NHS staff was subsequently held on 19th September, 2002 at Hampshire Police Support Headquarters. The following decisions were made at that meeting:

Further police enquiries were necessary in light of the new information and an enquiry team would be assembled and based at Hulse Road, Southampton. The enquiry team would:

- Examine the new documentation and investigate the events of 1991;

- Review existing evidence and new material in order to identify any additional viable lines of enquiry;
- Submit the new material to the experts and subsequently to CPS;
- Examine individual and corporate liability.

It was decided that a press release was necessary, which would include a free phone telephone number for concerned relatives to contact police.

Third Police Investigation

On 23rd September, 2002 Hampshire Major Crime Investigation Team commenced enquiries. Initially, relatives of 62 elderly patients contacted police with regards to the deaths of the patients at GWMH. A number of these relatives are part of a family group being represented by a firm of solicitors, namely ALEXANDER HARRIS of Manchester. Others contacted police through an NHS direct free phone number or directly, as a result of publicity.

During his review of patients medical records at GWMH, Professor Richard BAKER identified 16 cases which were of concern to him in respect of pain management. These 16 cases together with 12 other cases which transpired during the Police investigation have brought the total number of cases reviewed by the Police to 90.

The third police investigation has been conducted in stages, as follows:

Stage One

Enquiries into the documents and events of 1991. (Now completed)

In summary, the events of 1991 were as follows:

- A number of night-nursing staff at GWMH had concerns as earlier stated and held a private meeting to discuss the issues. They were conscious of an on-going case within the NHS of GRAHAM PINK, a Charge Nurse working in the care of elderly patients in Stockport, who was dismissed for "whistle blowing".

- It was decided that three of the nurses would approach the hospital management and raise their concerns. The nurses raised their concerns with the Patient Care Manager, Isabel EVANS.

- A series of meetings took place between management, medical and nursing staff.

- A final meeting took place in which the nursing staff were informed by both the hospital management and medical staff, that the problems raised were due to a lack of understanding by nursing staff concerning the use of Diamorphine. In addition, there was also a training issue in relation to syringe drivers.

- Although the nursing staff were not entirely happy with the outcome of the meetings, they felt that they had done everything they could in raising the issues, but in light of the PINK case, felt there was no more they could do, apart from retaining the documentation.

Stage Two

Obtaining further expert medical opinions/screening process.

A team of medical experts (key clinical team) was appointed to review all 90 cases. This team was headed by Professor Robert FORREST a specialist in Toxicology, the other members being experts in the fields of General Medicine, Palliative Care, Geriatrics and Nursing.

Their terms of reference were to examine the patient notes independently and to assess the quality of care provided to each patient. The Clinical Team was not confined to looking at the specific issue of syringe drivers or Diamorphine but to look at the overall care in general. The purpose of the reviews being to screen the cases and identify where appropriate, areas for concern that may warrant further investigation by the Police. At the same time they could identify cases where there were no concerns and the treatment that had been provided was appropriate in the circumstances.

A matrix was devised by them to allow each patients care to be scored and assessed. Using this system patient care was categorized and cases were placed in one of the three below categories:

1. Optimal care
2. Sub – Optimal care
3. Negligent care

The team was provided with approximately 20 cases for review every three months. At the conclusion of each review stage the experts attended a Conference where they could collectively discuss their findings and present them to the investigative team.

Each expert was briefed regarding the need to keep their notations and findings for possible disclosure to interested parties at a later stage in line with CPIA 1996. They were not required however, to produce evidential expert reports for reliance at Court on each individual.

The key clinical team reviewed a total of 90 cases and identified 13 cases that fall into category 3, a similar number in category 1 and the remainder being category 2.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN, before the decision was made that there was no basis for further criminal investigation.

Cases in category 2 have been referred to the General Medical Council and the Nursing and Midwifery Council for their respective considerations.

Category 3 cases are being further investigated in stage three of the investigation. These cases were placed in further categories in relation as to the cause of death as follows:-

A natural
B unclear
C unexplained by illness

Stage Three

Obtaining medical expert evidence and submission of case file(s) to CPS

Two further medical experts have been appointed to review all 13 of the cases in category 3 with a view to determine causation and, if required, give evidence in court. These experts are Dr Andrew WILCOCK and Dr Robert BLACK and have been required to work independently of each other.

In respect of each case these experts are reviewing medical records, statements from medical and nursing staff, statements from family members of deceased and transcripts of suspect interviews. They are also being provided with any reports or other documents, such as the CHI report and hospital protocols, specifically requested by them.

The experts were also provided with 'Guidance for Medical Experts' document which assists them to understand the terms Criminal Gross Negligence and Unlawful Act within the context of Homicide.

Below are the 10 category 3 cases which Dr's WILCOCK and BLACK are reporting on but not necessarily in this order.

1. Elsie DEVINE
2. Elsie LAVENDER
3. Arthur CUNNINGHAM
4. Sheila GREGORY
5. Robert WILSON
6. Enid SPURGEN
7. Code A
8. Helena SERVICE
9. Ruby LAKE
10. Geoffrey PACKMAN

Files of evidence in respect of each case are being submitted piecemeal to CPS for their consideration in the following format.

Confidential information
ROCHESTER case summary
Specific case summary
Expert report Dr WILCOCK
Expert report Dr BLACK
Witness list
Family member witness statements
Medical and Nursing witness statements
Police officer witness statements
Transcript suspect interviews