The CPS incorporates RCPO

**Review of Operation Rochester**

**Gosport War Memorial Hospital**

**Suspect: Jane Barton**

**Background and Scope**

1. Operation Rochester began in 1998 and sought to establish if there was sufficient evidence to charge Dr Jane Barton with manslaughter arising from her use of opiates in the treatment of elderly patients at the Gosport War Memorial Hospital which might have hastened death.

2. Apart from the Police enquiry there was also an Inquest and a General Medical Council disciplinary hearing against Dr Barton and full transcripts of these were considered by the CPS.

3. The final CPS decision in August 2010 concluded that the code test was not passed as there was insufficient evidence and no realistic prospect of conviction. The issues for each deceased was considered separately and were outlined for each deceased in a letter dated 16th August 2010 which is attached as Annex 1. In short negligence and causation could not always be proven due to the age of the patients, the use of opiates and the principle of double effect Where causation and negligence could be shown this was not considered capable of the determination "gross negligence" This decision was taken with the assistance of advice from David Perry QC and followed a thorough review of all the evidence, transcripts and other material available.

~~A copy of the final decision letter dated 16th August 2010 is attached as Annex 1~~

~~3.~~4. In 2002 following publication of a critical Commission for Health Improvement (CHI) report and ~~W~~while the police inquiry was proceeding the Chief Medical Officer

**Comment [HG1]:** It may be useful to say at this early juncture why the CPS decided NFA eg. Causation could not be proven due to the age of the patients, the use of opiates and the principle of double effect. The bland insufficient evidence does not really give the reader much information

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at the Department of Health commissioned an independent audit of care at the Hospital to review the deaths of elderly patients. This review was conducted by Professor Richard Baker of the Clinical Governance Research and Development Unit at Leicester University. The report was completed and submitted in October 2003 but was not published by the Department of Heath until August 2013. I refer to this report as the Baker Review

~~4.~~5. It should be noted that all the investigations into Dr Barton and the hospital coincided with heightened public anxiety following the arrest and subsequent conviction of Dr Harold Shipman. Enquiries following the Shipman murders revealed gaps in the monitoring of health care professionals including the death certification process. At the time there were fears that there were more professionals like Dr Shipman working in the health system. The Government wanted to reassure the public by clarifying steps which could be taken to identify existing and future mortality anomalies and to prevent Shipman type abuses in future.

~~5.~~6. I have been asked to answer two questions about the Baker Review~~this report~~

- Whether CPS knew about the Baker Review ~~2003~~ report when the case was reviewed after 2003 and
- if the Baker Review ~~report~~ was not available or considered would the content affect the CPS review conclusions.

~~6.~~7. This is a ~~Because of my~~ limited remit~~;~~ I have read the various review documents and~~-~~ correspondence on the CPS file. I have not reviewed the evidence itself. I have been made aware of a Freedom of Information Act application which shows that ~~t should be noted that~~that the original ~~-~~evidential ~~material~~file submitted by the police was accidentally destroyed by the Record Management Unit.

**Was the report available and considered**

~~7.~~8. Due to the accidental destruction of the police evidence it is not possible to give a clear answer about whether the report was available when the case was considered. However, there are clear references in correspondence which indicate that the CPS Police, Victim families and their representatives ~~parties~~ were aware of its existence. The below are samples of the references.

**Comment [HG2]:** Which report? The Baker Review? Keep consistent references

**Comment [HG3]:** As above

**Comment [HG4]:** As above

**Comment [HG5]:** Would some reference or detail regarding this be sueful eg. as per statement of ….or as per email of…

**Comment [HG6]:** Which 'parties'? Do you mean CPS and if so whom – reviewing lawyer, management etc. The CPS is an organisation, it may be useful to analyse who knew what.

~~8.~~9. There is mention in the press during 2002 about the commissioning of Professor Baker to conduct an audit of mortality at the hospital. The Professor had conducted a similar exercise during the Shipman enquiry. The Health Service Journal on 19th September 2002 says

- *The Gosport move comes two months after Hampshire Police and the Commission for Health Improvement* (CHI) *collaborated on an investigation into the use ~~sue~~ of prescription painkillers at the hospital. It found that between 1997 and 2000 patients at Gosport had been regularly over-prescribed painkillers. Though the CHI is unable to determine whether these levels of prescribing contributed to the deaths of any~~an~~ patients, it is clear that had adequate checking mechanisms existed in the trust this level of prescribing would have been questioned*

~~9.~~10. The Baker Review is referred to in internal briefing notes and correspondence with the Police. In a document from Police to CPS dated 10th June 2004 the penultimate paragraph says

- *One significant issue to be addressed is informing the families of the 16 deceased named as "cases of concern" in the Baker report commissioned by the CMO. Two of these cases,* **Code A** *nd SERVICE identified through the independent work of Professor Baker have been assess as 3b's by the experts commissioned through the Police investigation.*

~~10.~~11. There is a letter dated 22nd June 2009 in which the SIO DI Grocott of Hampshire Police tells Paul Close of SCD

- *"This report formed part of the generic case file submitted to you on 23rd August 2005 and was further discussed during a meeting with yourself and counsel on 28th September 2005".*

~~11.~~12. The Baker review is also referred to in correspondence from family members and their solicitor representatives. On the 3rd June 2009 Blake Lapthorn {Solicitors who represented some of the deceased' families) wrote to the reviewing CPS lawyer Paul Close:

**Comment [HG7]:** To whom?

**Comment [HG8]:** To whom?

- " We are also aware that there is a report from Professor Baker which we understand demonstrates the statistical effects of the treatment regime at Gosport Memorial Hospital. Neither the evidence from Professor Forrest nor that from Professor Baker has ever been made available to the families and it was not produced at the inquest hearing before Mr Bradley"

~~12.~~13. And the CPS decision letter of 16th August 2010 at paragraph 22 refers to a letter dated 11th April 2010 from Blake Lapthorn

- "you emphasised the importance of Professor Baker's epidemiological study"

~~13.~~14. Outside the papers available I have seen reference on a website in which the Department of Health say the report was supplied to the Police. This led to a freedom of information request to Hampshire Police by family members although the police response was that they did not have a copy of the report.

~~14.~~15. Unsurprisingly, given the passage of time and the high volume of material generated by this case, the lawyers and caseworkers who worked on the case are unsure if they had seen the report before its recent publication.

~~15.~~16.Because of the uncertainties, I cannot be sure that the report was specifically studied at the time of the decision and therefore my judgements are made on the basis that the CPS did not have a complete copy of the report even though they were probably aware of its existence and high level conclusions.

**What Impact could this report have on the CPS conclusions**

~~16.~~17. It is important to understand that the role of the CPS when reviewing this case was to decide whether or not the code test as set out in the Code for Crown Prosecutors was passed. The stages are, in short; was there a realistic prospect of conviction on the evidence available and if so; is it is in the public interest to prosecute the offence. The offences under consideration in this case were manslaughter based on gross negligence by Dr Barton. The letter of August 2010 in

**Comment [HG9]:** Written by whom?

**Comment [HG10]:** When?

**Comment [HG11]:** When?

**Comment [HG12]:** Whom within CPS?

Annex 1 sets out in detail the tests and evidential issues facing the prosecutor and their conclusion that there was not a realistic prospect of conviction.

~~17.~~18. The Baker Review, which forms Annex 2 followed investigation work by the CHI, the aims of the review were:

Comment [HG13]: Full name?

- *To identify any excess mortality or clusters of deaths among patients who were on the Daedalus and Dryad wards 1988-2000 and to identify initial evidence to explain any excess or clusters.*
- *To determine whether the numbers of deaths among Dr Barton's general practice patients was higher than would have been expected.*

~~18.~~19. The Baker Review methodology is an analysis of clinical information from surviving documentation; it is made clear that this was not an investigation into the death of any individual.

  - *"The review does not consider statements from witnesses and does not involve a forensic inquiry into particular deaths, since these aspects are the proper responsibility of the police and other agencies" (page16)*

~~19.~~20. Page 27 sets out the structure of the chapters and it can be seen that the analysis relies on data from a random sample of clinical records, the numbers of deaths at the hospital, findings from a ward admission book, information from controlled drug registers and information recorded in death certificates as cause of death.

~~20.~~21. At the time of the Baker Review it was not possible to undertake any comparison of death rates between hospitals which would have assisted in identifying anomalies in anticipated mortality rates. The 'summary of findings' at page 5 says

  - *"..it was not possible to identify an adequate source of data about numbers of deaths in similar hospitals which admitted similar types of patients in the same time periods to enable a reliable estimate of excess deaths to be calculated. Nevertheless the findings tend to indicate that the finding of a statistical excess of deaths among patients admitted to Gosport is unlikely"*

~~21.~~22. The conclusions chapter ~~summary of findings~~ starts on page 115 and highlights the evidence of ~~for~~ a pattern of opiate medication from 1988. There is some statistical support for the proposition that opiates were used more readily on Dr Barton's ward though there was no evidence to say she prescribed these for a longer period than other doctors.

Comment [HG14]: Slightly confusing as said above at page 5 – probably best to put this statement above

23. There is ~~also~~ an observation that Dr Barton did not record cause of death in the same way as other doctors when a fracture was involved. ~~Apart from that anomaly~~

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~~22.~~24.~~t~~There was no statistical finding that there were clusters of deaths associated with Dr Barton nor was there statistical evidence of any abnormal patterns of deaths. For instance there was nothing to show that death frequently occurred shortly after the administration of large amounts of opiates or on particular days of the week.

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~~24.~~25. Professor Baker also commented on the practice of overprescribing and its consequences saying on page 119

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- *..it is difficult not to conclude that the some patients given opiates should have received other treatment. Only a detailed investigation of individual cases in which the accounts of witnesses as well as documentary evidence are considered can conclude whether lives were shortened by the almost routine use of opiates before death, but I would expect such case by case investigations to conclude that in some cases the early resort to opiates will be found to have shortened life…and to have shortened the lives of (some) people who would have had a good chance of surviving to be discharged from hospital"*

~~25.~~26.It should be noted that establishing the truth of this comment for specific deceased people was the focus of the police (and coronial) investigations. The Baker R~~r~~eview itself does not provide any specific statistical analysis to support this comment.

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~~26.~~27. It can be argued that any statistical analysis has to be treated with caution and this is particularly true in medicine which involves all the variables of the human body. The reliability of the conclusions in this report have to be qualified as the data

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was incomplete and the sample sizes often relatively small; correcting for variables such as annual leave or a short term change in admission policy perhaps due to closure of a local nursing home can easily distort the outcome data disproportionately. The limitations of the report are clearly acknowledged by Professor Baker as is clear from the extract above.

~~27.~~28. The issues raised about the use of opiate prescribing and note keeping formed the basis of some of the findings at the subsequent GMC hearing leading to disciplinary action and restrictions on Dr Barton's practice.

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~~28.~~29. The question I am asked to consider is whether the Baker Review contained any evidence which would affect the CPS decision in this case. I conclude that it would not have any impact because

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- The report is based on historic statistical and documentary records only and
- The report contained no evidence about the treatment of specific patients and
- The specific findings of the report were not put to those involved so, for instance, Dr Barton and her colleagues were not asked if there were any explanations for the anomalies exposed. This limitation is recognised by Professor Baker and would be likely to result in admissibility issues and

Comment [HG15]: Why. The lack of option to respond to allegations is not usually a basis for s.78 inadmissibility.

- Professor Baker made it very clear that the intention of the report was not to investigate individual allegations which was the role of the police, the report instead highlighted questions and areas for further investigation and practice improvements and
- While the report provided context and background, the judgements made would not easily be admitted to a criminal court as relevant evidence against an individual because of issues regarding statistical interpretation and
- Even if admitted the conclusions would be compromised due to limitations around error in data sources, sample size as well as the lack of quality assurance on the data
- There is also a major issue about the relevance of such a statistical analysis given the nature of the questions being asked when considering a manslaughter case of this type.

Comment [HG16]: Is it worth referring to cases where statistical data is criticised?

- There is no judgement or evidence in this report which assists the CPS to answer the main questions which would have to be proved beyond reasonable doubt to secure a conviction for manslaughter

**CONCLUSION**

~~29.~~30.I have found some evidence that the Police used data from the Baker Review to assist in the identification of potential victims. However, I have not found reliable evidence that the report content was considered by the CPS lawyers, though the CPS was aware of the existence of the report.

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~~30.~~31.In conclusion the Baker Review is a statistical analysis and audit of historical information relating to the hospital and Dr Barton. Tt provided background information about prescribing practice and was of assistance in identifying patients for further investigation. The Baker Review contains no specific evidence relating to the treatment of individual patients which would assist the proof of issues required for elements of gross negligence manslaughter. ~~For the reasons stated in paragraph 27 above~~ I do not consider that the report would change the CPS conclusion that there was insufficient evidence for a realistic prospect of conviction.

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Comment [HG17]: I wonder if a short summary of the key reasons why the report is unhelpful may be useful otherwise you leave all the justification to your conclusions to a long series of bullet points above.

Hilary Reeve
Crown Prosecution Service.
October 2013