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 was permitted to observe subsequent proceedings which involved 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 Nurses BARRETT and HALLMAN, 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 BARRETT was such that she had to be stopped by the Panel's legal representative from criminalising herself, which would surely have followed if she had been allowed to go on. In the event, 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, Shirley HALLMAN, RING, LLOYD, SHAW, BARRETT and TURNBULL and it has been apparent for some time that they all had a hand in his demise in just five days after being admitted for bed-sores, under the reckless prescribing of an irresponsible doctor. The consequences of Dr BARTON's actions will surely be decided by the GMC 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 and excessive increases of opiates until death ensued, which is what happened to my step-father. It is clear from the evidence that I have heard personally, that this was common practice in Dryad Ward at that time, and that once a syringe-driver was started it was never stopped. Furthermore, HALLMAN in her evidence said that she herself found it unacceptable to discover patients on syringe-drivers upon returning to duty who in her opinion did not need them when she finished duty the day before. An adequate explanation was never forthcoming, and this resulted in a breakdown of relations between HALLMAN and her superiors. She also said that starting doses were frequently far too high as were the subsequent step-increases.

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 for whatever reason and, as I now know from recent evidence (Nurse Shaw), 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 in this world as, despite all the evidence over the years including formal complaints by nurses in the early 1990s about the misuse of syringe-drivers and a damning report by the Council for Health Improvement, the NMC seem to have sat on its hands in a state of blind ignorance.

I look forward to your reply.

Yours faithfully,

Charles Stewart-Farthing

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AvMA (Peter Walsh)
Blake Lapthorne (John White)
Various members of the National Press