22/4/09

reports from five medical experts into deaths at War Memorial hospital

nobody heard

REPORT No 2

■ **Professor David Black**, an independent specialist in elderly care, consultant geriatrician at Queen Mary's Hospital, Sidcup, Kent, and chairman of the England Council of the British Geriatrics Society
■ Details of report partially revealed to the jury.

Professor Black was asked by Hampshire Constabulary to look at the elderly patient deaths at Gosport War Memorial Hospital.

He was called on to give evidence at the inquests but Andrew Bradley, deputy assistant coroner for Portsmouth and south-east Hampshire, ruled the jury would not be given the full report and it would not be read out in court.

In giving evidence, Prof Black raised concerns about the levels of medication given to 88-year-old Elsie Devine prior to her death.

He told the jury: 'I remain concerned about the levels that were given and I would want to see and hear the justification for it.'

He said doses of morphine given to 82-year-old Leslie Pittock, who died on Dryad ward on January 24, 1996, were 'more than I would have conventionally expected, and I was not able to find a reason for that in the notes'.

REPORT No 3

■ **Dr Andrew Wilcock**, a consultant in palliative care at Nottingham City Hospital and clinical reader at the University of Nottingham's school of molecular medical sciences. ■ Details of report partially revealed to the jury.

Hampshire Constabulary called on Dr Wilcock to look into the deaths of 10 elderly patients at Gosport War Memorial Hospital.

Dr Wilcock had conducted research into pain relief medication prescribed to 100 terminally-ill elderly patients in Nottingham. He found the median dose of the drug prescribed to them in the last 24 hours of life was just 40mg – far lower than doses given to some of the 10 patients at the Gosport War Memorial who were the subject of the inquest.

During evidence he said there was 'no defence' for giving elderly patients excessive doses of powerful drugs at the hospital.

Dr Wilcock said he could find 'no justification' for the wide range of morphine and sedative doses prescribed to some patients, and 'disagreed completely' with the pre-prescription of 20mg to 200mg of the painkiller diamorphine to some patients.He also criticised poor note-keeping by GP Jane Barton. Dr Wilcock also claimed Dr Barton exposed patient Elsie Devine to inappropriate and/or excessive doses of midazolam and diamorphine that could have contributed to her death.

But his full report was not fully released at the inquest.

REPORT No 4

■ **Professor Richard Baker**, head of the Department of Health Sciences and professor in quality and healthcare at the University of Leicester.
■ Report was not revealed to the jury.

Professor Baker was drafted in by the chief medical officer to conduct what is believed to be an audit on deaths of elderly patients at Gosport War Memorial Hospital.

Liam Donaldson called on Prof Baker following his independent report into murders of more than 200 elderly patients by serial killer Harold Shipman in West Yorkshire.

It is believed Prof Baker's report shows an increase in deaths at the hospital in the 1990s.

The government has so far refused to publish the report, despite appeals by relatives, and a request made under the Freedom of Information Act by charity Action Against Medical Accidents.

The Department of Health says it could be used as evidence if the General Medical Council decides to hold a fitness-to-practise hearing for Dr Jane Barton – the doctor at the centre of the inquest. And Andrew Bradley, assistant deputy coroner for Portsmouth and south-east Hampshire, announced that he would not take the report's findings in evidence before swearing the eight-strong jury in at the inquest into 10 elderly patient deaths at Gosport War Memorial Hospital.

REPORT No 5

■ Toxicologist **Professor Robert Forrest**, an honorary professor at the University of Sheffield and a world leader in his field.
■ Report was not revealed to the jury.

Led a team of four experts who investigated drug doses at Gosport War Memorial Hospital after being commissioned by Hampshire Constabulary.

The screening team – which consisted of four doctors including two experts in palliative care and a nurse – produced notes and minutes which were handed to the Crown Prosecution Service.

It is believed the teams findings were then handed to experts for analysis and to help form part of subsequent reports.

A number of the deaths were categorised as being 'of serious concern'.

However, Andrew Bradley, deputy assistant coroner for Portsmouth and south-easst Hampshire, decided not to call Prof Forrest to give evidence.

Following a short debate on day one of the inquests Mr Bradley decided – before the eight-strong jury was sworn in – that the team's findings would not be presented to them.

TIMELINE

■ October 1998: First police investigation is launched, but dropped three weeks later.
■ November 1998: A second police probe is launched following further complaints by Gillian Mackenzie. It lasts three months and the Crown Prosecution Service decides not to take it to court.

The Police Complaints Authority launches an investigation into the two police probes following complaints from grieving families.

The complaints are upheld.
■ October 1999: Third police inquiry starts.
■ July 2000: Dr Barton resigns from her hospital contract citing pressure of work.
■ January 2001: Police files are sent to the Crown Prosecution Service.
■ July 2001: The Crown Prosecution Service decides there is insufficient evidence for prosecutions.
■ August 2001: Police ask NHS watchdog the Commission for Health Improvement – now the Healthcare Commission – to look into the deaths at Gosport War Memorial Hospital.
■ April 2002: Fresh complaints about the latest police probe are made to the Police Complaints Authority.
■ November 2002: Police launch Operation Rochester into the deaths. In total 92 deaths are examined and hundreds of NHS staff are interviewed before the numbers are whittled down by medical experts.
■ November 2004: The first files from Operation Rochester are sent to the Crown Prosecution Service.
■ October 2005: Head of Independent Police Complaints Commission apologises to families for the 'unacceptable length of time' the investigation has taken.
■ February 2006: Families are told the Independent Police Complaints Commission has launched a probe into its own work.

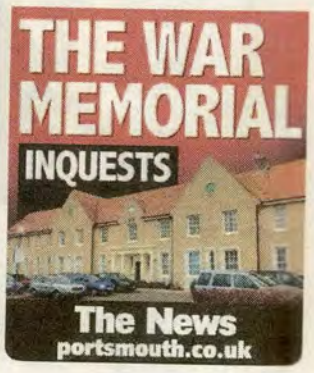
Dr Jane Barton

■ May 2006: Independent Police Complaints Commission confirms the officer in charge of the previous police probe should have been given a verbal warning over the conduct of the case.
■ July 2006: Police say all Operation Rochester files are now with the Crown Prosecution Service.
■ December 2006: The Crown Prosecution Service announces that none of the cases will go to court.
■ May 2008: Portsmouth and south-east Hampshire coroner David Horsley opens and adjourns an inquest into the deaths of the following 10 patients at Gosport War Memorial Hospital in the late 1990s after approval from Justice Secretary Jack Straw:
■ April 20, 2009: The jury of five women and three men return verdicts that powerful painkillers contributed to the death of five of the 10 patients and in three cases – Elsie Devine, Geoffrey Packman and Robert Wilson – the does given were inappropriate.
■ Late 2009: The inquest into Gladys Richards's death is expected to be held in Portsmouth and a General Medical Council inquiry into Dr Barton is then expected to be held.

22/4/09

INQUESTS: Families of dead patients slam decision by coroner not to let jury hear the full

The crucial evidence



Charles Farthing and other realtives speak outside court earlier this week

PICTURE:MALCOLM WELLS (091413-4472)

by Clare Semke
Health reporter

FAMILIES today criticised a coroner for leaving compelling evidence out of the inquests into 10 deaths at the Gosport War Memorial Hospital.

Andrew Bradley refused to allow the full reports from five experts to be put before the eight-strong jury.

He also withheld details of three police probes, a Crown Prosecution Service investigation and a damning report by a health watchdog which raised fears over drug administering practices at the Bury Road hospital.

In excluding evidence, Mr Bradley said he wanted to 'avoid fingerpointing and the issue of liability'.

Many of the families point blame on Dr Jane Barton, who was in day-to-day charge of the now defunct Daedalus and Dryad wards at Gosport War Memorial at the time of the deaths between 1996 and 1999.

The jury at Portsmouth Crown Court concluded on Monday that medication prescribed by Dr Barton contributed to the deaths of five elderly people.

The relatives now want all the evidence to be heard in public and are pushing for a full public inquiry or another police investigation

John White, a barrister who acted on behalf of some of the families during the unprecedented inquests, said in his view the jury should have been given the reports so they could make a more informed decision.

He said: 'If it had been a public inquiry we would have seen more evidence because it would have a less narrow remit.

'At the moment we still don't really know what happened. It would have made it a lot easier to understand the case if they had been given the information at the outset.

'You can't have reconciliation without understanding, and you can't have understanding without being able to see the overall picture.'

Damning evidence not presented to the jury included:

- A Hampshire police briefing revealing there had been 'a failure of trust systems to ensure good quality care'.
- A 'death audit' carried out by Professor Richard Baker at the hospital.
- A report by expert Dr Andrew Wilcock alleging that Dr Jane Barton had exposed one of the patients to inappropriate or excessive doses of drugs that could have contributed to her death.
- Levels of diamorphine administered through syringe drivers described in a report as 'reckless' and 'poor practice'.
- Fears by the former Commission for Health Improvement over the quantity and pre-prescribing of drugs.
- And reports from a world leader in toxicology who categorised a number of elderly deaths as being 'of serious concern'.

Charles Farthing, whose 79-year-old stepfather Arthur Cunningham, known as Brian, died on Dryad ward in September 1998, said: '[The inquest] was biased towards the medical profession.

'The coroner started before the inquest by telling us the families would have transparency and an opportunity to see everything they needed to see and that everything would be made available, but it has been stifled from the word go.

'The whole thing has been a total waste of public money.'

Inquests can only be used as a fact-finding mission to identify the deceased, as well as how, when and where they died and their details.

When approached by *The News* the coroner, Andrew Bradley, refused to comment on why certain evidence was not allowed.

But before the month-long inquests got underway he said he wasn't prepared to take any evidence which could apportion blame.

The jury said in the verdicts that strong painkillers contributed to the deaths of Elsie Lavender, 83, Brian Cunningham, 79, Robert Wilson, 74, Geoffrey Packman, 68, and Elsie Devine, 88.

In the Wilson, Packman, and Devine cases the drugs prescribed were 'not appropriate' for the conditions from which the patients were suffering, the jury concluded.

However, the jury said all of the deaths were from natural causes and that medication did not contribute to the deaths of Leslie Pittock, 82, Helena Service, 99, Ruby Lake, 84, Enid Spurgeon, 92, and Sheila Gregory, 91.

Hampshire's Chief Constable Alex Marshall yesterday said there were no plans to reopen the case but he would look at the verdict.

'I will wait for the coroner to produce his verdict in writing, I will very carefully read that verdict and if anything new emerges we will reconsider our position,' he said.

The Department of Health also said it would not hold a public inquiry despite pleas from families.

Dr Barton declined to comment.

REPORT No 1

Professor Gary Ford, expert in pharmacology of old age at Newcastle University.
Report not revealed to jury.

Investigated five elderly patient deaths at Gosport War Memorial Hospital at the request of Hampshire Constabulary.

Two of those – 88-year-old Robert Wilson and 79-year-old Arthur Cunningham, known as Brian – were the subject of the inquests.

Prof Ford branded levels of diamorphine administered through syringe drivers 'reckless' and 'poor practice.'

And he said Mr Wilson's rapid deterioration after being admitted to the Dryad ward at the hospital could have been caused by the diamorphine he was given.

Alcoholic Mr Wilson, who had a broken arm, died four days after being admitted on October 18, 1998.

Prof Ford, whose evidence was handed over to the Crown Prosecution Service in 2001, said the skills of nursing and non-consultant medical staff, 'particularly Dr Barton, were not adequate'.

Concluding his report, he wrote: '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 [Dryad] ward.'

'The whole thing has been a total waste of public money'