

# 'It should have

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Families with relatives who died in Gosport War Memorial Hospital are happy that a panel look at dozens of unexplained deaths. **ELISE BREWERTON** reports on a long campaign for justice

**R**elatives of patients who died unexpectedly at Gosport War Memorial Hospital have welcomed the announcement of a major inquiry into the deaths.

Health minister Norman Lamb yesterday confirmed a panel headed by the former Bishop of Liverpool the Right Rev James Jones, who chaired the Hillsborough inquiry, would look into 92 deaths at the hospital in the 1990s.

Ernest Stevens, whose wife Jean died on Daedalus ward in 1999, said: 'This should have happened before now.'

'The entire thing needs looking into. From day one it was wrong. When I spoke to my wife the night before she was moved from Haslar to the War Memorial hospital she was bonny and she was talking to us.'

'I went in the next day and she was in a coma.'

Mrs Stevens, a great-grandmother from Fareham, was one of scores of patients whose deaths were looked into by Professor Richard Baker whose review was finally published last year.

The findings of the report revealed an over-prescription, and in some cases over-use, of opiates, and that note-taking had been poor.

The Baker report took 10 years to become public after the police probes and inquests were completed. It also found Dr Jane Barton, who was in charge of the now defunct wards, had a higher percentage of patients whose cause of death was put down to bronchopneumonia, and prescribed a higher number of opiates before a patient's death.

It also found there 'were no clear clusters of deaths', but the proportion of patients at Gosport who did receive opiates before death was 'remarkably high'.

An inquiry by the General Medical Council into Dr Barton's fitness to practise in 2010 found there was no justification for the powerful painkillers and sedatives prescribed to Mrs Stevens, 73, who died two days after being admitted for rehabilitation.

It was also found that some of the drugs prescribed were inappropriate, potentially hazardous and not in Mrs Stevens' best interests.

Dr Barton did not seek advice when Mrs Stevens' condition deteriorated and was found guilty of poor note

keeping.

The panel was not satisfied Mrs Stevens was properly assessed before being given strong drugs.

Mr Stevens, 88, said: 'I know my wife did not die of pneumonia. She never saw Dr Barton when she was in hospital but a prescription was made out for her before she even arrived.'

'This has dragged on for so long - it should have been dealt with long ago.'

'Every time something new comes up we get very upset but we need answers.'

'We (the victims's families) are all in the same position. This is for all of us.'

Marjorie Bulbeck's mother Dulcie Middleton was transferred to Gosport War Memorial Hospital (GWMH) for rehabilitation from Haslar Hospital after her health improved following a stroke in 2001.

But her condition deteriorated rapidly once she was admitted to GWMH and Mrs Bulbeck, from Southbourne, fought to have her moved to Petersfield Cottage Hospital where she died, aged 86.

Mrs Bulbeck, 72, has since received an apology from the NHS about her mother's treatment at GWMH which she sums up as 'lack of food, lack of water, lack of care'.

She said: 'When I first started this I thought I was the only one. It quickly became clear this was happening on a wide scale.'

'I'm so pleased that there will finally be an inquiry.'

'There are 90 families who have been caused distress, have been sending letters looking for answers.'

'We're not going to bring them back but I think we need, for our own peace of mind, to think that we have done something for them to prove that they were not looked after properly. And to see things improve in the future.'

Following Prof Baker's report Mr Lamb met families to decide what action to take.

Beryl Wilson said her late husband Mike would have been 'thrilled' that an inquiry is finally taken place.

He was one of the first to call for an inquiry after his mother Edna Purnell died aged 91 at GWMH in 1998.

Mrs Wilson, from Gosport, said: 'Mike fought really hard for this but in the end he gave up as he thought it would never happen.'



**INVESTIGATION** Gosport War Memorial Hospital and inset, Dr



**MINISTER** Norman Lamb

## Minister says

CARE and support minister Norman Lamb has been looking into the deaths at Gosport War Memorial Hospital for several years.

In a statement he said: 'The events at Gosport War Memorial hospital have caused immense distress to the families of the patients who died.'

'I was deeply concerned by the findings of the Baker report, and I am confident that the appointment of Bishop James Jones to chair this independent process will help answer the many questions of the families affected by these shocking events.'

Mr Lamb said the investi-

# been dealt with long ago'



Jame Barton

**Relatives welcome the retirement of doctor in hospital deaths case**

Older students learn from each of

...what an official told colleagues when this grieving woman demanded answers about the death of her mother

**'The fun starts here...'**

...what an official told colleagues when this grieving woman demanded answers about the death of her mother

**Family unhappy at result of hospital death inquest**

**'OPIATE USE AT HOSPITAL CUT LIVES SHORT'**

Document on Gosport hospital

**FLASHBACK** The News of, from the top, March 30, 2010; September 23, 2010; April 18, 2013; and August 3, 2013

## TIMELINE

- August 1998: Gladys Richards dies at Gosport War Memorial, with daughter Gillian Mackenzie already complaining about her care.
- October 1998: First police investigation launched, lasting just three weeks before being dropped.
- November 1998: Following further complaints from Mrs Mackenzie, a second police probe is launched. The Crown Prosecution Service (CPS) decides not to take it to court.
- The Police Complaints Authority (PCA) launches a probe into the two police investigations after complaints from families that they were inadequate. The complaints are upheld.
- October 1999: Third police inquiry begins.
- January 2001: Case files sent to CPS, but six months later CPS concludes there is insufficient evidence for prosecution.
- August 2001: Police ask NHS watchdog the Commission for Health Improvement (CHI) to look at events at the hospital.
- April 2002: New complaints to the PCA about the most recent police probe.
- July 2002: CHI publishes a damning report concluding hospital patients were being put at risk by poor practice.
- September 2002: Department of Health asks Professor Richard Baker to carry out a 'death audit' at the hospital to see if unusual numbers of people were dying.
- November 2002: Police launch Operation Rochester into the deaths. At its peak, 92 deaths are examined, and hundreds of NHS staff interviewed, before the numbers are gradually whittled down after files are sent to a host of medical experts.
- April 2004: The PCA is replaced by the new Independent Police Complaints Commission (IPCC).
- November 2004: First files from Operation Rochester sent to CPS.
- October 2005: IPCC boss apologises to families for the 'unacceptable length of time' its investigation has taken.
- February 2006: Families are told IPCC investigations continue, and it has launched



**RELATIVE** Gillian Mackenzie

- a probe into its own work.
- May 2006: IPCC confirms the officer in charge of previous police probe should have had a verbal warning for the conduct of the case.
- July 2006: Police say all Operation Rochester files are now with the CPS.
- December 2006: CPS announces that none of the cases will go to court.
- Early 2008: Police files passed to coroner.
- March 2009: Jury inquest begins.
- April 2009: Jury rules drugs prescribed by Dr Jane Barton contributed to the deaths of Elsie Devine, 88, Elsie Lavender, 83, Robert Wilson, 74, Brian Cunningham, 79, and Geoffrey Packman, 68.
- In the cases of Geoffrey Packman, Elsie Devine and Robert Wilson drugs prescribed were not appropriate for their conditions.
- The jury finds all 10 deaths were from natural causes.
- January 2010: The General Medical Council Fitness to Practise Panel finds Dr Barton guilty of 'multiple instances of serious professional misconduct.'
- She is not struck off. Instead she is subject to 11 conditions to remain on her licence for three years.
- August 2013: Ten years after it was ordered the 'death audit' review by Prof Baker is published.
- Its findings are damning. The report finds the use of opiates 'almost certainly shortened the lives of some patients, and it cannot be ruled out a small number of these would otherwise have been eventually discharged from hospital alive.' It says opiates were often prescribed before needed.
- July 2014: Health minister Norman Lamb announces Hillsborough-style inquiry to be launched into the deaths.

## he wants to get to the bottom of 'shocking events'

gation was expected to take about two years and would review the evidence held by a number of organisations, including investigations by police, NHS the General Medical Council and inquests.

Mr Lamb worked closely with Iain Wilson, from Gosport, whose father Robert, 74, died at the 1998, and the cause of death was put down to bronchopneumonia.

Mr Wilson died four weeks ago without knowing the inquiry was about to be announced.

Gosport MP Caroline Dinenage also welcomed the

inquiry.

She said: 'For the families involved, this has been a long and hard journey.

'I am pleased that the government has expressed its commitment to addressing their ongoing concerns and finding out what really happened at Gosport War Memorial Hospital.

'I have always called for openness and transparency - the families deserve nothing less.

'The inquiry, selected by the families as their preferred course of action, is an important first step in finally bringing closure to this difficult case.'

There have been three police inquiries but no charges were ever brought.

A spokeswoman for Hampshire police said there are no current investigations.

However, depending on whether new evidence comes to light during the new government inquiry, that could change.

Dr Jane Barton, then the clinical assistant at the hospital, was found guilty of multiple instances of serious professional misconduct but was not struck off by the General Medical Council at a Fitness to Practise Hearing in 2010.

Instead conditions were

placed on her registration, including a ban on prescribing opiates for injection, for three years.

The Medical Defence Union, which represented Dr Barton, said it was unable to comment.

Speaking on behalf of the nurses at the hospital at the time the Royal College of Nursing said: 'RCN members have co-operated with inquiries over the past decade and will continue to do so in the hope that the full facts can finally be established. We are committed to ensuring patient safety and where there are lessons to be learnt taking them fully on board.'