From: Code A
Sent: 16 May 2011 17:37
To: Code A
Cc:
Subject: RE: GMC hearing

Dear Code A

Thank you for your reply.

We confirm that the Police did give us statements from Haslar staff but these were not provided to the Fitness to Practise Panel for the reasons explained in my prior email.

Although we appreciate the importance of the forthcoming Inquest, as the GMC is not a party to it we do consider that our representation at it is warranted.

Yours sincerely
Code A

From: Code A
Sent: 15 May 2011 13:51
To: Code A
Subject: GMC hearing

Just back from pre-inquest hearing in Portsmouth . Thank you for your information – can you just confirm that you did in fact receive statements from Police for Haslar staff – even if you did not use them. I have now seen Code A s statement and the new medical opinion obtained by the Coroner – very encouraging. I was represented at the pre-inquest by a barrister from Tooks Chambers. The inquest will take place in the Autumn – I hope there will be a representative from the GMC there purely out of interest whoever represents me then. Code A

TELEPHONE MESSAGE PAD

FROM .....

TO .....

TIME/DATE .....

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Code A

Code A

– Regional Director of

Code A

Code A

Code A

's office)

Code A

:– Director of Public Health at Code A

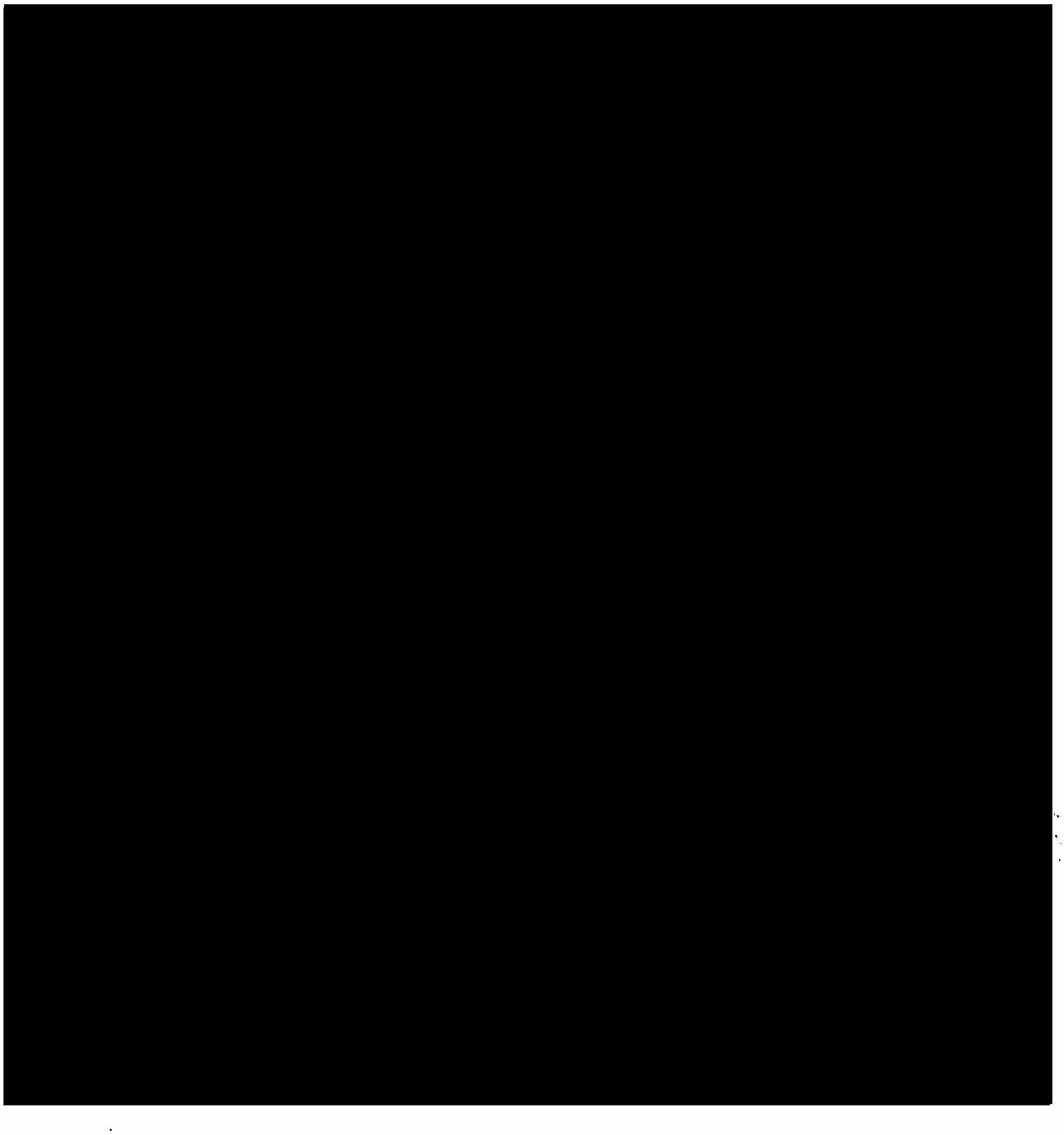
Health Authority

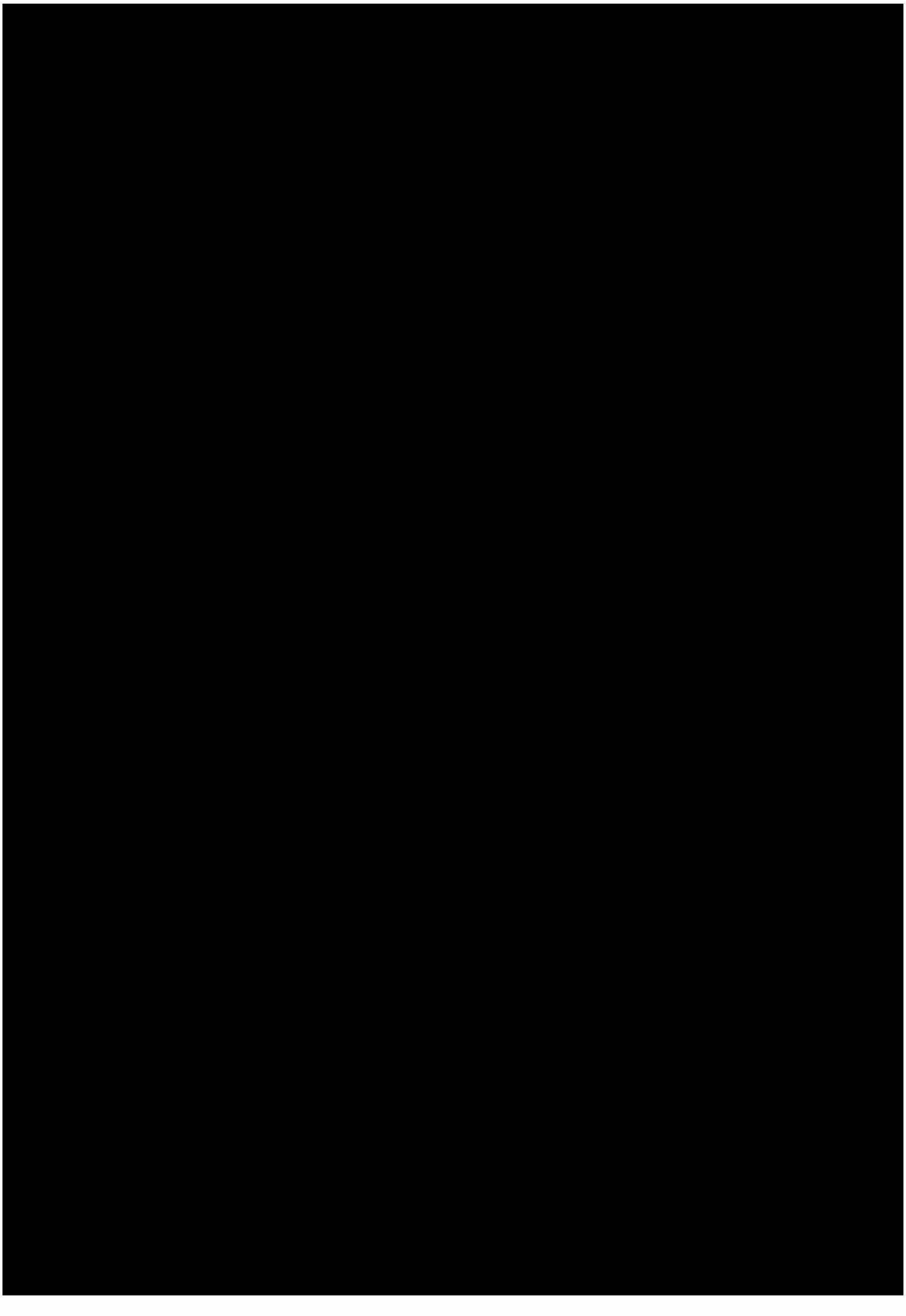
Message taken by .....

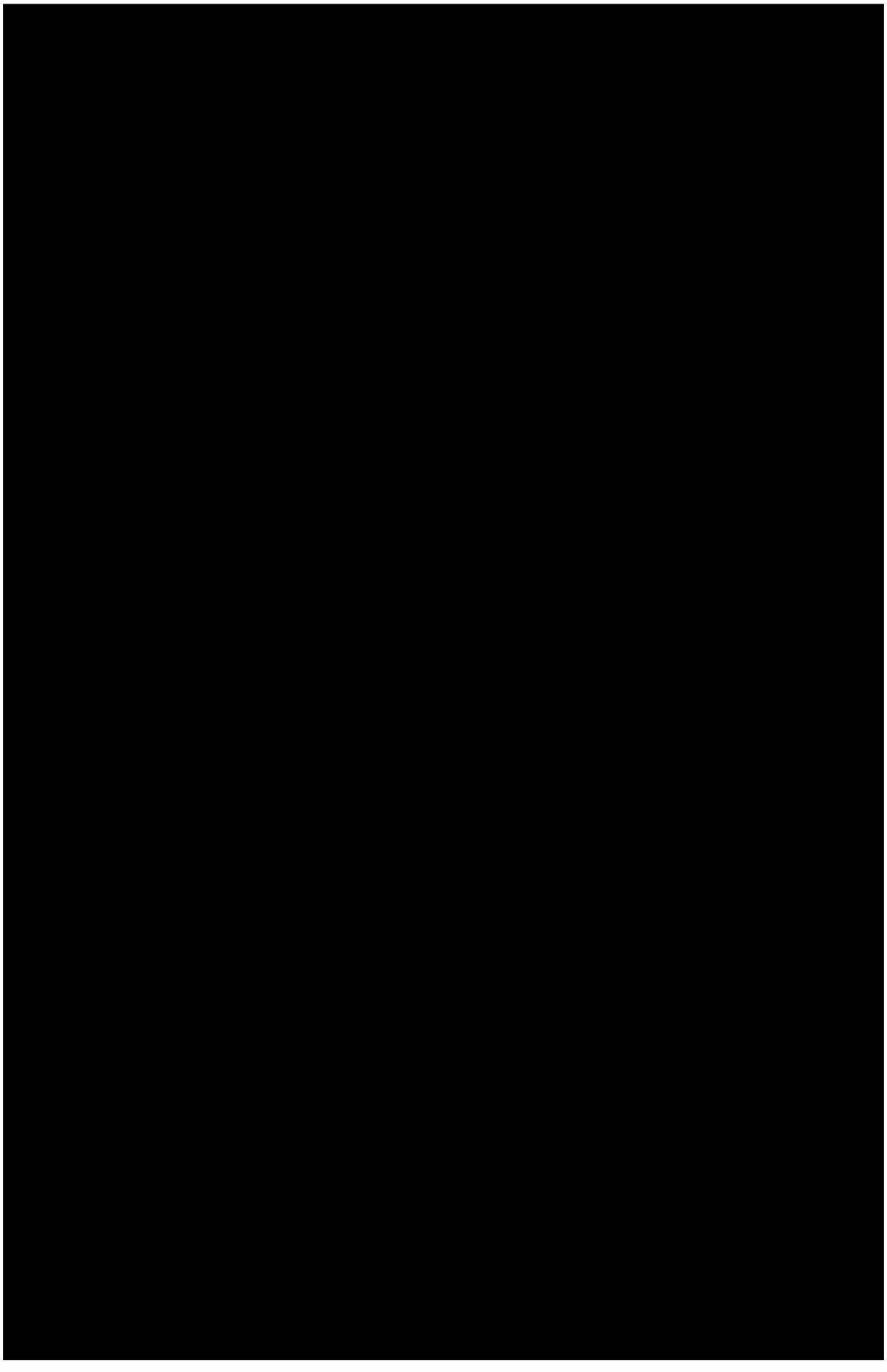
Code A

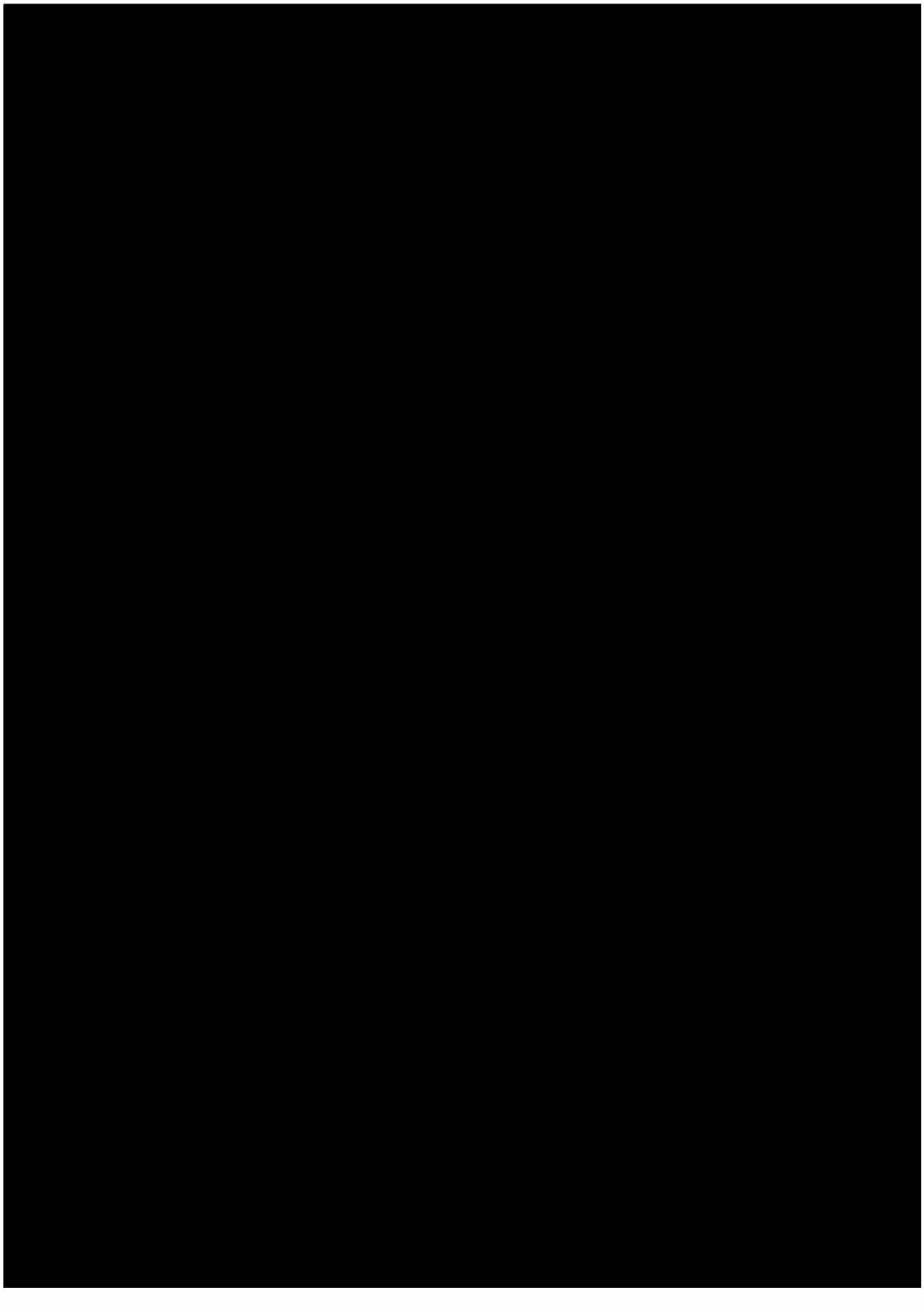
Code A

NOTES FOR CONSULTATION
Wednesday, 26 May 2004









GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Code A

CASE OF: Code A

PROCEEDINGS

T.A. REED & CO.

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Code A

CASE OF:

Code A

Code A Counsel, instructed by Messrs Field Fisher Waterhouse, Solicitors to the Council, appeared to present the facts.

Code A Counsel, instructed by the Medical Defence Union, appeared on behalf of Code A who was present.

PROCEEDINGS

Transcript of the shorthand notes of T A Reed & Co,
13 The Lynch, Hoddesdon, Hertfordshire, EN11 3EU
Telephone No: 01992 465900

A Code A: Good morning everyone. May I formally open the proceedings. We move on to the case of Code A is present and is represented by Code A counsel, instructed by Code A of the Medical Union. Code A counsel, instructed by solicitors to the Council, represents the Council.

B Code A, may I say first of all, I am conscious that you are currently Code A and that you have recently Code A I do appreciate your being here today. If at any stage you feel you want a break, or need to take a temporary break, then please do not hesitate to say so. I do appreciate the fact that you have come along.

(Introductions made)

C If there are no further points, then I will ask Code A to open the proceedings this morning, please.

Code A: This case involves the inappropriate prescribing to five patients at the Gosport War Memorial Hospital between February 1998 and October 1998, five patients whose ages range between 75 and 91, and who all died at the hospital. Code A at the material time was a general practitioner and also a Code A in elderly medicine at the hospital.

D To give the Committee some idea of the history of the case, the police began an investigation into the circumstances of the death of one of those patients, Code A Code A That investigation later extended to four other patients. The Interim Orders Committee has considered this matter, as you have already said, on two occasions before. Firstly, June 2001, when it was considering only the matter of Code A and on that occasion no order was made.

E In February 2002, the Crown Prosecution Service decided not to proceed with the criminal proceedings. Then the Crown's papers were disclosed to the General Medical Council and thus the matter came before the Interim Orders Committee again on 21 March this year, and again no order was made.

F The present position as I understand it is that the Crown Prosecution Service is reconsidering their original decision and there always remains a possibility that there may be proceedings in relation to one or more of these patients. There has also been a PPC hearing which took place at the end of August this year. The PPC referred the matter on to the PCC but they made no interim order with regard to registration at that time.

G Code A: Sorry? They referred to the PCC?

Code A: They have, yes. So, in other words, what has changed in a sense is the fact that the matter is now being referred on to the PCC and the possibility of criminal proceedings has raised its head again. Thus the matter has been referred to this Committee for its consideration today.

H The information in relation to these matters is set out in pages 4, 5, 6, 7 and 8. I will come on to facts in relation to those five patients. You will also have within your

bundle, inter alia, a report from Code A and I am going to refer to some of his conclusions whilst dealing with each of the patients.

May I deal first with the patient Code A She was admitted to the Dryad Ward which was one of the wards in which Code A worked on 27 February 1998. She came under the care of Code A She was there for palliative care. She had a possible carcinoma of the bronchus. She died on Code A She was 87 years old. She had originally been admitted to the Queen Alexandra Hospital on 6 February 1998, after her condition deteriorated over the preceding five days.

On 7 February 1998, she was noted to have a low mood, to be frightened and X-rays showed a potentially malignant mass superimposed on the right hilum. On 12 February 1998 a management plan was set up, which was to give palliative care in view of her advanced age. On 16 February 1998, there was a gradual deterioration in her condition. She had no pain but she was confused and she was continued on antidepressants. It was on 27 February, as I have said, that she was transferred to the ward and came under the care of Code A On the day that she was transferred, Code A wrote in the medical notes that she was transferred to Dryad ward, continuing care. Diagnosis of carcinoma of bronchus, CXR on admission.

> "Generally unwell, off legs, not eating, bronchoscopy not done, catheterised, needs help with eating and drinking; needs hoisting; Barthel – 0. Family seen and well aware of prognosis. Opiates commenced. I'm happy for nursing staff to confirm death."

The nursing notes confirm that she had been admitted for palliative care.

On 28 February 1998, she was noted to be not in pain. She was administered Thioridazine and Oramorph. She was distressed.

On 2 March 1998, she was noted to be very distressed and Code A noted that adequate opioids to control should be administered. She had fear and pain. Therefore 5 mg of diamorphine was administered by a syringe driver.

On Code A a rapid deterioration of her condition is noted. Diamorphine, Midazolam was commenced by syringe driver. It is this prescription which is the subject of criticism by Code A She died on that day, death being recorded at 21:30. His criticism is that there was no indication that Code A was in pain or distress, and with a frail, elderly and underweight patient that prescription was potentially very hazardous and poor practice, but he concluded that it was probably for palliative reasons that it had been prescribed by Code A

Code A is another doctor who has made a report in this case and in relation to this case, he concluded that Code A had a clinical diagnosis of lung cancer.

Code A Is there a page number?

Code A I am sorry, madam. It is page 57.

A

> "There was no documentation of any pain experienced. When she was transferred to Dryad ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding symptom control and she was started on opioid analgesia, in my view, inappropriately."

He comments:

B

> "The prescription for subcutaneous diamorphine infusion again showed a tenfold range from 20 mg to 200 mg."

In his conclusion is:

> "The reason for starting opioid therapy was not apparent in several of the cases concerned."

C

That is the conclusion overall. Can I deal secondly with Code A She died on Code A She was 81. She had been admitted on 6 August 1998 to the Daedalus ward where Code A worked. She had been admitted to that ward for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection. In fact, she had been admitted to the Queen Alexandra Hospital on 31 July 1998. She was found to have a fever. She was given intravenous antibiotics. By 3 August the fever had settled and she was improving. She had severe dependency needs but on transfer to the Daedalus ward it was noted that her bed should be kept at her care home.

D

The nursing notes state that she was transferred to the Daedalus ward for a four to six week assessment and observation and then a decision would be taken about placement. In other words, it was intended that she would leave Daedalus ward to go back to some form of care home.

E

On 10 August it was noted that she was eating and drinking better and that she would be reviewed in one month, and if there was no specific special medical or nursing problem she would be discharged.

F

The next entry in the notes is by Code A on 21 August.

Code A Can we have a page, please?

Code A Page 79. There it is noted by Code A

> "Marked deterioration over last few days. Subcutaneous analgesic commenced yesterday. Family aware and happy."

G

A final entry on the same day is at half past six in the evening when death is confirmed but there had been no entry that Code A had been in pain on 20 August or in the preceding days, and no analgesic drugs had been administered to her before. It appears that Code A had prescribed a regular daily prescription of diamorphine, 30 mg over 24 hours, and Midazolam, 20 mg over 24 hours. That had been started to be prescribed to Code A from 13:50 on 20 August, therefore the Code A

H

died. They were administered to her again on 21 August. There was no indication for the use of those drugs, no explanation as to why, and Code A notes that it was poor practice, potentially very hazardous in a frail, elderly and underweight patient, and it could result in profound respiratory depression, and her death was possibly due, at least in part, to respiratory depression from the diamorphine, or that diamorphine led to the development of bronchopneumonia.

Code A comments on this patient at page 55 of the bundle. He said:

> "There was no clear indication for an opioid analgesic to be prescribed, and no simple analgesics were given and there was no documented attempt to establish the nature of her pain. In my view the dose of diamorphine that was prescribed at 30 mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the diamorphine prescription gave a tenfold range from 20 mg to 200 mg in 24 hours."

Can I now turn to the matter of Code A, which was the matter originally investigated by the police. Madam, I am looking here at page 62.

She had been 91 years old when she was admitted as an emergency to the Haslar Hospital on 29 July 1998. She fractured the right neck of her femur. She had dementia. There had been a deterioration in the quality of her life over the previous six months. She had surgery for the fracture on 30 July 1998 and she was then referred to Code A, who is a Code A physician in geriatrics on 3 August 1998. He concluded that despite dementia, she should be afforded the opportunity to remobilise her.

On 10 August 1998, just prior to her transfer to the Daedalus ward, it was noted:

> "[She] is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Code A needs total care with washing and dressing eating and drinking. Code A is continent, when she becomes fidgety and agitated a meantime she want the toilet. Occasionally incontinent at night, but usually wakes."

The following day, 11 August, she was transferred to the Daedalus ward. On that date, Code A had written in the medical notes.

> "Impression frail demented lady, not obviously in pain, please make comfortable. Transfers with hoist, usually continent, needs help with ADL Barthel 2. I am happy for nursing staff to confirm death."

The nursing notes recall that she is now fully weight bearing and walking with the aid of two nurses and a Zimmer frame. However, on 12 August, the notes recorded that a little before midnight she had been very agitated, shaking and crying. Did not settle for more than a few moments. However, she did not seem to be in pain.

It seems the following day that she had been found on the floor at 13:30. No injury was apparent at the time but her right hip was internally rotated, and another doctor had been contacted for an X-ray.

On 14 August, Code A had noted that sedation and pain relief had been a problem. Screaming was not controlled by haloperidol but very sensitive to Oramorph. Code A had also proposed the rhetorical question, "Is this lady well enough for another surgical procedure?" It seems that she was, because she was readmitted to the Haslar Hospital. The hip was manipulated under sedation, and that was successful. She was discharged back again to the Daedalus ward on 17 August. Again it was noted that although she had been given a canvas knee-immobilizing splint which must stay in situ for four weeks, she could however mobilise full weight bearing. But the nursing notes on that day record that when she had been transferred back she had been very distressed and appeared to be in pain. Later that day, she had been given Oramorph 2.5 mg in 5 ml. A further X-ray was performed which demonstrated no fracture, so that was not the source of the pain. Pain demonstrated. Code A had also noted that on 17 August, the day of transfer back, she had been under i/v sedation during the closed reduction. She remained unresponsive for some hours and –

> "... now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See Code A again."

On 18 August, it was noted she was still in great pain, nursing a problem.

> "I suggest subcutaneous diamorphine, haloperidol/Midazolam. I will see daughters today. Please make comfortable."

The nursing notes say that she had been reviewed by Code A for pain control via syringe driver. It was further noted that she reacted to pain when being moved.

On 19 August, the nursing notes recorded that she was comfortable and she was apparently pain free. There appear to be no notes at all for 20 August, but the next entry is Code A 's on 21 August, where she records:

> "much more peaceful. Needs hyoscine for rattly chest."

She recorded as her overall condition deteriorated.

> "Medication keeping her comfortable."

The time of death is recorded as being 21:20 Code A . The cause of death was recorded as bronchopneumonia.

One can see set out on page 64 the dates and times of the various medication and opiates that were given to her during her time on the ward.

Code A 's treatment is criticised by Code A . He says that even in a woman of Code A s age, there were good reasons to offer surgery for the fractured neck of the femur because without it, the patient remains immobile and nearly invariably develops serious and usually fatal conditions. He notes that Code A believes that she had potential to benefit from rehabilitation, and that would have been implicit in her transfer to the Gosport War Memorial Hospital to receive rehabilitation there. It seems that Code A did not appreciate that that was the reason for her rehabilitation and one knows from the papers that Code A made a statement to the police. She

A was asked about her entry on initial transfer to the Daedalus ward, the entry which said, "I am happy for nursing staff to confirm death," when Code A had been apparently transferred from rehabilitation. Code A told the police that she appreciated there was a possibility that Code A might die sooner rather than later, and regarded the admission as a holding manoeuvre.

B Code A sets out reasons why Code A's approach to Code A might well have been different to Code A's. He concludes at the end of paragraph 2.18 that Code A's experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

C In paragraph 2.19, he sets out Code A's explanation for the administration of drugs to Code A He criticises some of her conclusions. He says that screaming is a well-described behavioural disturbance in dementia. It can be due to pain, but is often not. He concludes that there was not a proper clinical examination of the reason for the screaming because of course, he says, if the screaming had been worse on weight bearing or on movement, that would have provided supportive evidence that screaming was from pain, as opposed to dementia.

D He notes that Code A had not been prescribed opiates before she was transferred to the Daedalus ward, he says:

> "This makes me consider it probable that Code A prescribed ... Oramorph, diamorphine, hyoscine, and Midazolam when she first saw Code A and she was not in pain."

He said:

E

> "I do not consider it appropriate to administer intermittent doses of Oramorph to Code A before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. ... Code A's statement that diamorphine and Oramorph were appropriate analgesics at this stage following surgery when she had been pain free is incorrect and in my opinion would not be a view held by the vast majority of practising general practitioners and geriatricians."

F He also criticises the fact that there are no notes of fluid or food intake after Code A was readmitted to the Daedalus ward on 17 August, and between that and her death on Code A He says that although there were no clear descriptions of her conscience level in the last few days, her level of alertness appears to have deteriorated once the subcutaneous infusion of diamorphine, haloperidol and Midazolam was commenced. It seems that she was not offered fluids or foods, and

G intravenous or subcutaneous fluids were not considered as an alternative. He says the decision to prescribe oral opiates and subcutaneous diamorphine to Code A on initial admission to the Daedalus ward was, in his opinion, inappropriate and placed Code A at significant risk of developing adverse effects of excessive sedation and respiratory depression.

H The prescription of oral paracetamol and my Lady opiates would have been appropriate and would have had a better risk/benefit ratio. The prescription of

A subcutaneous diamorphine, haloperidol, and Midazolam infusions "to be taken if required" was inappropriate even if she was experiencing pain. It goes on to explain why. He says:

> "The prescription by Code A on 11 August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Code A at serious risk of developing coma and respiratory depression had these been administered by the nursing staff. It is exceptionally unusual to prescribe subcutaneous infusion of these three drugs with powerful effect on conscious level and respiration to frail elderly patients with non-malignant conditions in a continuing care or slow stream rehabilitation ward and I have not personally used, seen or heard of this practice in other care of the elderly rehabilitation or continuing care wards. The prescription of three sedative drugs is potentially hazardous in any patient but particularly so in a frail older patient with dementia and would be expected to carry is high risk of producing respiratory depression or coma"

He goes on in paragraph 2.27 to consider Code A 's statement in relation to the use of Midazolam which he said was inappropriate.

Code A made a statement to the police in relation to this matter which is in your bundle. At the end of it, she says ---

Code A Page number, please? Is it page 153?

Code A It is page 153 – thank you, madam. At the end of that, at page 162, paragraph 38, she says:

> "At no time was any active treatment of Code A conducted with the aim of hastening her demise. My primary and only purpose in administering the diamorphine was to relieve the pain which Code A was suffering. Diamorphine can in some circumstances have an incidental effect of a hastening a demise but in this case I do not believe that it was causing respiratory depression and was given throughout at a relatively moderate dose."

At paragraph 39, she says similarly:

> "Similarly it was not my intention to hasten Code A death by omitting to provide treatment for example in the form of intravenous or subcutaneous fluids. By the 18th August it was clear to me that Code A was likely to die shortly."

She did not believe that transfer to another hospital would have been in her best interests.

I now turn to Code A was 79 years old. He had had Parkinson's disease since the mid-80s. By July 1998, he had Parkinson's disease, dementia and depression. When he was seen on 21 September 1998 in the Dolphin Day Hospital by Code A she recorded that he was very frail, tablets had been found

A in his mouth, he had a large necrotic sacral sore with thick black scar. His Parkinson's disease was no worse.

Code A Is this page 72?

Code A It is, madam, yes. He decided to transfer him to do Dryad ward on that day. The entry by Code A on 21 September says:

B

> "Make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death."

She decided to prescribe and administer diamorphine and Midazolam by subcutaneous infusion on the evening of 21 September, so the evening of the day that he was admitted. Code A 's opinion of that, at paragraph 3.10 was that he

C considered the decision by Code A --

> "... to prescribe and administer diamorphine and Midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate, particularly when there was a clear instruction by Code A that he should be prescribed intermittent"

D – apparently underlined –

> "doses of Oramorph earlier in the day. I consider the undated prescription by Code A of subcutaneous diamorphine..."

and he gives the amounts –

E

> "to be poor practice and potentially very hazardous. In my opinion it is poor management to initially commence both diamorphine and Midazolam in a frail elderly underweight patient such as Code A . The combination could result in profound respiratory depression and it would have been more appropriate to review the response to diamorphine alone before commencing Midazolam, had it been appropriate to commence subcutaneous analgesia, which as I have stated before was not the case."

F

Apparently it had been prescribed and administered for pain relief and to allay anxiety but there was no clear recording that Code A was in pain or, indeed, where the site of the pain was, if it existed.

On 23 September, it was noted that he had been chesty overnight and deteriorated. Code A 's conclusion is:

G

> "The symptoms could have been due to opiate and benzodiazepine induced respiratory depression. The family were told that Code A was dying."

But on 24 September 1998, Code A reviewed him and he was apparently in pain. On 25 September dosages were increased threefold. There was no record of

H Code A receiving food or fluids since his admission to the Daedalus ward on

A the 21st despite the fact that Code A had prescribed a high protein diet for him when she transferred him to the Dryad ward. He died on Code A a little before midnight. The cause of death was recorded as bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer.

Code A was also concerned about the initial note entered by Code A on 21 September, that she was happy for nursing staff to confirm death, because – as he says – there was no indication by Code A that Code A was expected to die"

B

Code A I am sorry to interrupt. I am slightly confused because on page 72, it is suggested that Code A had made that entry. I take it you are saying that that is wrong. It is paragraph 3.2.

Code A I think there had been a further entry by Code A on the 21st, saying

C that she was happy for nursing staff to confirm death. It was when Code A was admitted to the Dryad ward on 21 September, having seen Code A in the Dolphin Day Hospital. It was on that day that Code A was recording, "Am happy for nursing staff to confirm death."

Code A I am sorry. I see they are both recorded.

D

Code A Yes. I think Code A 's point was that there was no indication on the day that he was first admitted that there would be any indication of death ensuing in the near future. Code A notes that it is possible that Code A died from drug induced respiratory depression without bronchopneumonia present, or from the combined effect of bronchopneumonia and drug induced respiratory depression as a result of the drugs which had been prescribed to him.

E

Code A comments upon Code A 's case at page 54. He says:

> "All the prescriptions for opioid analgesia are written in the same hand and I assume they are Code A 's prescriptions … Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two doses of oral morphine, the 24 hour dose requirement of diamorphine could not therefore be established. The dose of diamorphine prescribed gave a tenfold range from 20 mg to 200 mg in 24 hours which is an unusually large dose range in my experience."

F

- just in parenthesis, one which is common to Code A 's prescriptions in all these cases.

> "The patient was reviewed by Code A on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40 mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view, morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication."

G

H

Lastly, might I turn to Code A I will be referring to notes on page 83. Code A was a 75 year old man. He had been admitted to the Queen Alexandra Hospital on 22 September 1998. He had a fracture of the left humerus. Morphine had been administered to him intravenously and then subcutaneously but he developed vomiting. Two days later, when he was given 5 mg of diamorphine he had lost sensation in the left hand. Five days later, it was noted that he had poor quality of life and poor prognosis, and he was not to be resuscitated.

However, by 7 October he had apparently stated that he did not want to go to a residential home and wanted to go home. Although he had previously been sleepy, withdrawn and in a low mood, when he was seen by Code A, the Code A in old age psychiatry on 8 October, he was much better. He was eating and drinking well, and appeared brighter in mood. His Barthel score was 5/20. It was noted that he had been a heavy drinker over the previous five years and that he had possible early dementia, Alzheimer's disease or possible vascular dementia.

On 13 October it was noted that he required both nursing and medical care. He was at risk of falling and that what would be appropriate would be a short spell in long-term NHS care.

On 14 October he was transferred to the Dryad ward. An entry on the same date by Code A reads:

> "Transfer to Dryad ward continuing care. HPC fracture humerus, needs help with ADL ... hoisting, continent, Barthel 7. Lives with Code A Plan further mobilisation."

I think here it is recorded as being 16 November, but that must be wrong because he had died by then. On 16 October, the notes record that he declined overnight, and gave details of that. He had a possible silent myocardial infarction and Code A had written a prescription for subcutaneous diamorphine, hyoscine and Midazolam and that was administered to him on 16 October. Again, this is a course of action criticised by Code A

I am looking at paragraph 5.12. He says:

> "I am unable to establish when Code A wrote the prescription .... as these are undated. The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate. The prescription of a single dose of intravenous opiate is standard treatment for a patient with chest pain following myocardial infarction is appropriate standard practice but was not indicated in Code A s case as he did not have pain. The prescription of an initial single dose of diamorphine is appropriate as a treatment for pulmonary oedema if a patient fails to respond to intravenous diuretics such as frusemide. Code A was not administered intravenous frusemide or another loop diuretic."

He says it is an inadequate response to Code A s deterioration.

In the following 48 hours, the increase of diamorphine was from 40 mg/24 hours and then 60 mg/24 hours. At paragraph 5.13, Code A says that that increase was not appropriate when the nursing and medical notes record no evidence that Code A was in pain or distressed at this time.

> "This was poor practice and potentially very hazardous. Similarly the addition of Midazolam and subsequent increase in dose to 40 mg/24hr was in my opinion highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive."

He notes that there were no justifications for those increases in those three drugs written in the medical records.

On 17 October, Code A was noted to have deterioration variously described in one place as rapid and another place as slow, but on Code A there had been a further deterioration and his death was recorded at 23:40 that night.

Code A again comments on this case at page 56. He says:

> "Code A was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given..."

and he notes that there was an entry earlier in the episode of care that Code A had refused paracetamol.

> "No other analgesia was tried prior to starting morphine."

He notes that once again, the diamorphine prescription had a tenfold dose range as prescribed. He also considered that the palliative care given was appropriate.

Code A on page 53, sets out sets out the appropriate use of opioid analgesics. He says:

> "Opioid analgesics are used to relieve moderate to severe pain and also can be used to relieve distressing breathlessness and cough. The use of pain killing drugs in palliative care (ie the active total care of patients whose disease is not responsive to curative treatment) is described in the British National Formulary which is the standard reference work circulated to all doctors in Great Britain."

Code A I have not interrupted you before but...

Code A It is surely Code A ?

Code A : Code A yes.

Code A I have let you go to some detail in the cases you have gone through, but I think you can assume that we have read the papers. I think if you could perhaps summarise rather than read the papers it would be helpful, and just pick out the points you think are particularly worth stressing.

Code A as I am sure you have read, sets out the way that treatment should be given, and what should be tried before going on to a further treatment. His conclusion in relation to these cases can be found at page 57:

> "The reason for starting opioid therapy was not apparent in several of the cases concerned."

They had not been given for long enough to ascertain the appropriate dose. Professor Ford also draws conclusions at the end of his report at page 59. He makes certain criticisms of Code A s prescribing at the end of that report, and as detailed in the middle of it, as I have already set out.

Code A I think his conclusions are at page 93 and 94.

Code A Yes, they are. Thank you, madam. Just to bring matters up to date, there is a letter from Code A s solicitors which can be found at page 404, from the Medical Defence Union. That letter sets out in some detail Code A s response to these allegations which I am sure the Committee has read. It is obvious that Code A has ceased to provide medical care for the adult patients in the hospital, and she has voluntarily stopped prescribing opiates and benzodiazepines. As I said at the beginning, these matters have been considered before but the change in circumstances is the possible reconsideration of the matter by the Crown Prosecution Service, and the fact the matter has gone to the Professional Conduct Committee for their consideration.

Code A Do you have any recommendations?

Code A No, madam.

Code A Can I just be quite clear about the sequence of events here? You referred to two previous IOC hearings?

Code A Yes.

Code A Am I right, the first one, I think you said, was in June 2001, and only considered the case of Code A ?

Code A That is right, yes.

Code A The second one in March this year, did it consider all five cases?

Code A Yes, it did.

Code A And the PPC hearing on 29 August, did they consider all five cases and the papers that we have today?

Code A As far as I am aware, yes.

Code A And the referral back to the IOC now did not come from the PPC?

Code A No, madam.

Code A It came from the Code A ?

Code A That is right.

Code A And you are saying it is because the CPS have now re-opened. I forget your wording.

Code A They are reconsidering their original decision not to pursue the criminal ---

Code A But we have no papers to give us confirmation of that, or to give us any further... I am just trying to be clear how the situation has changed. So the only change has been that we have information, we know not how we got it, that the CPS are reconsidering.

Code A That is right, although, as I am sure Code A will tell you, the defence have been in contact with the officer in the case who is happy with the original decision that was taken by the Crown Prosecution Service not to proceed with the criminal proceedings. But, of course, it is not a decision which is taken by the police. It is a decision which is taken by the Crown Prosecution Service, whether to institute or discontinue proceedings.

Code A We do not know why the situation has changed?

Code A My understanding is that the families of the patients involved were unhappy about the decision which was originally taken. You will notice in your bundle that they have written letters directly in the very recent past to the General Medical Council, to make complaints about the way that their parents were treated. I think, to be fair to Code A there has been a degree of pressure brought upon the Crown in this case to reconsider the matter.

Code A That is helpful. Did you want to say anything?

Code A Is there no additional material or evidence since the last hearing of the IOC?

Code A As far as I understand it, there is no additional material.

Code A Most unusual circumstances. Does any other member wish to raise any points of clarification? (No reply) I just wonder whether the Committee ought to have a brief in camera session before we go further.

Code A I wonder whether Code A has anything to say about this?

Code A Can I help you. It may be, after I have made the few remarks that I have to say, that may assist a short in camera deliberation.

Code A who sits besides me, who is the author of the letter that you see at page 404, setting out observations on behalf of Code A two days ago spoke to Code A Code A, who is the Code A with the Hampshire constabulary. He is coordinating the police investigation into these five cases. He is an experienced police officer. He has been producing a guide for police generally, investigating cases of alleged medical manslaughter. He is not a police officer who has no experience of looking at this sort of investigation, this sort of case.

The police originally investigated the case of Code A and you will see a reference, I think on page 13 of the bundle, to a letter to the GMC in August 2001, that Senior Treasury Counsel – that is a senior criminal barrister – was asked to look at the case and the evidence in relation to Code A The advice provided to the Crown Prosecution Service, which informed the police decision, was that there was case to be prosecuted.

Police subsequently looked into the other four cases and the view that they took was that those cases raised similar issues to that of Code A In their analysis – this comes from the attendance note of a telephone conversation between Code A and Code A The police analysis of those other cases was that it was the same, or raised the same issues as those that were raised in the case of Code A and upon that basis the police took the view that there was no case to be raised against Code A Subsequently there have been, as my learned friend has suggested, concerns raised on behalf of family members, relatives and the police have decided to send the case papers to the CPS. They have not yet gone. The understanding that Code A got from the conversation was that this was a case of back-covering – I can use that expression – by the police. The police were perfectly satisfied. They had no concerns. Because of concerns raised by family members, they thought, "We will get the CPS to check," and that is the basis upon which papers have been sent to the CPS. There is no new evidence. There are no fresh allegations, there is nothing else that the police have sent on to the CPS, essentially other than the papers that you have seen. Those are the same papers that were seen by the earlier Committee this year. Nothing – nothing – in reality has changed.

There is a lot more I would like to say if the Committee were going on to consider whether to impose conditions or other matters, but you have suggested you might want to deliberate shortly in camera.

Code A First of all, can I comment and then ask the Code A We certainly have precedents where the Committee considered at this stage whether they wish to continue to hear further evidence. It strikes me, in view of what we have heard, that this might be a case where I should deliberate with the Committee to see if they wish proceed with the remainder of the full hearing, if I can put it like that.

Code A Indeed.

Code A do you wish to comment?

Code A All I was going to say is this. Do you have any comments on the propriety - not the power but the propriety - of this Committee to consider again a matter on which the Committee has already decided without any fresh evidence at all?

In normal circumstances, you would say, if you like, it is res judicata, and I doubt whether that doctrine strictly applies to this Committee, but it may be something which the Committee should take into account.

Code A The normal circumstance in which a case might be reconsidered is if there is some fresh evidence or change of circumstances. It is advanced by my learned friend that there is a change of circumstances because this case has been referred by the Preliminary Proceedings Committee to the Conduct Committee and also the papers have now been sent to the CPS. I say those are somewhat manufactured as a change of circumstances. It is not a real change of circumstances. If there was further evidence or if there was another basis of concern about Code A 's practice, then that might alter matters. To the extent that the Committee may be concerned that they are invited to review an earlier decision, I agree entirely with the suggestion that they should decline to do so. I know at least one member of your Committee today was on the Committee that considered the case last time. That is Code A It seems a little strange that he should be invited to review the decision that the Committee he sat on then looked at.

I am prompted – the suggestion of back-covering is not an appropriate one. The police would not agree it, but that may be the effect of what is happening. The police were satisfied. They conducted their own inquiry. These are experienced police officers who are familiar with the concept of the gross negligence/manslaughter in a medical context. They did not see the need themselves to send the case to the CPS for further investigation. They have now done so because of concerns raised by the family, but there is no fresh evidence to place before the CPS.

I do not know that that answers the point. It is a response.

Code A I think it suggests that your thoughts are rather similar to my thoughts. I would really advise the Committee that without fresh material it would be only in extreme circumstances that the matter should be reconsidered again. I do not see evidence that there are such extreme circumstances. It could be that if the Preliminary Proceedings Committee had referred it here as part of their process of sending it to the Professional Conduct Committee that would be a factor which this Committee could take into account, but that is not the situation.

Code A The generality of the position is the same as it was before. Code A has, as you know, retired or resigned the job she held at the Gosport War Memorial Hospital back in 2000. You will have seen reference to correspondence in the transcript last time that she resigned because she felt she was under-resourced and could not do the job properly. That position clearly still holds. She is not in a position where she is dealing with those who are terminally ill or in the very last stages of their life. She continues to work full time as a GP subject to other matters. She does not routinely prescribe benzodiazepines or opiates.

The condition to which she agreed with the Health Authority - that she would not prescribe opiates or benzodiazepines - lapsed at the end of March of this year because there was initially a time limit put on it, and the Health Authority did not see fit to invite her to renew that undertaking. So as far as circumstances changing since the last hearing before the IOC, 21 March 2002, I think that is the only change. I am sorry: the

condition that she did not prescribe benzodiazepines or opiates was lifted by the Health Authority.

Code A, do you want to make any comment on the last few exchanges?

Code A Madam, no.

Code A: I think we should go into camera. As I see it, there are two issues here. One is whether there is new evidence since the last IOC hearing which justifies this Committee hearing the case afresh. The evidence is simply that we have heard that the CPS are reopening. The second, I think, is simply that the PPC have referred the case to the Professional Conduct Committee. That is the new evidence bit. If we decide that this is a full hearing and we are considering matters, then it is within our gift, and we certainly have precedent, that we can make a decision on the case if we feel minded to do so without hearing the full defence submission.

Code A Thank you. I can tell you, if you were to ask for my submissions, they would be brief. I would be reminding you of what appears in the letter at page 404, and the transcript of the evidence that Code A gave on the last occasion. I know you a familiar with them.

Code A: Thank you, Code A We will go the to camera. If it looks like we are going to be taking a lunch break before we conclude, then we will let you know, but I am not saying that at the moment.

PARTIES, THEN, BY DIRECTION FROM Code A WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA.

PARTIES HAVING BEEN READMITTED

Code A Before I read the determination, I am going to ask the Code A Code A to repeat the advice he gave us in camera.

Code A I advised the Committee that in light of the fact that there was no new evidence before them it would be unfair to the doctor for the Committee to consider the matter any further.

DETERMINATION

Code A

Code A The Committee has carefully considered the information before it today and has determined that it is not necessary for the protection of members of the public, in the public interest or in your own interests that an Order under Section 41A

of the Medical Act 1983, as amended, should be made in relation to your registration whilst the matters referred to the GMC are resolved.

The view of the Committee is that there is no new material in this case since the previous hearing of the Interim Orders Committee on 21 March 2002. The Committee has reached this determination in the light of this and Code A 's advice.

That concludes the case for this morning. Thank you for coming. I hope it has not impeded your convalescence too much. I appreciate it is stressful for you.

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

THURSDAY 7TH OCTOBER 2004-10-30

CHAIRMAN: Code A

CASE OF

Code A

Code A instructed by Messrs Field Fisher Waterhouse, solicitors to the Council, appeared for the Council.

Code A instructed by the Medical Defence Unit appeared on behalf of Dr Barton who was present.

Code A Good morning. I would just check that everybody has the addendum to the papers, there is addendum 1 which is paginated from 510 to 551 and addendum 2 which seems to be paginated from 533 to 563. Code A this is not the first time you have appeared before the Interim Orders Committee, the location is different, but the principles remain the same. The Panel is at this end of the table. Code A is to my far right, she is the lay member, Code A is the medical member, Code A is the legal assessor, and Code A Code A is the secretary, Code A is the lay member and Code A is the medical member of the Panel and my name is Code A I am the medical member as well, and also act as chairman. Code A appears for the council and Code A appears for you. We will start with Code A

Code A This matter has a long history but it is not a review hearing because in the previous three hearings no order has been made, nor is it an adjourned hearing, there have been no adjournments. It comes before you because the General Medical Council has just received a statement from Code A an officer of the Hampshire Constabulary who is in charge of the investigation comprehending acts and omissions of Code A Code A The statement shows the scale of the police concern on top of the reference which has already been made by the Preliminary Proceedings Committee to the Professional Conduct Committee of the Council for enquiry into certain matters concerning Code A There is no application for an adjournment although one has been requested in correspondence which you will have seen and is in one of the addendum bundles.

Because the matter has such a long history it seems to me it would be helpful to you and I provided this morning to my learned friend a chronology. It has already been partly over taken by events in that various things which I saw were missing have been produced but I hope you will find it is helpful and where I know there is some page references I will give them to you.

Code A We will refer to this as C1.

Code A The order that I would seek today is that there should be conditional registration of Code A I do not seek and in my submission it would not be appropriate to seek suspension of Code A So the primary reason why I seek conditional registration is to protect patients and to protect public interest and it would be my submission that in all the circumstances such conditions would be proportionate and that Code A would be able to continue in medical practice as a general practitioner.

I will come to suggested draft conditions in a few minutes if that will be convenient. If you have the chronology in front of you you will see that it begins on the first page with the period, which was the originally alleged period of inappropriate prescribing to five patients, aged between 75 and 91 at Gosport War Memorial Hospital and concerns two wards Dryad Ward and Daedalus Ward. as you will have seen from the papers, all of whom died at the hospital where Code A was a part-time Code A that is to say that patients Code A

Before going to those matters and going on may I begin by considering what it is I on behalf of the Council would need to establish and what it is what I would seek from you today. The

primary condition which we would ask for is that otherwise than in a medical emergency Code A Code A should neither issue nor write any prescriptions for nor administer benzodiazepines or opiates. Other fairly standard forms of conditions about notification of employers and prospective employers and not undertaking positions elsewhere where registration is required without informing the IOC secretariat we would also obviously ask for.

The points that I would make apropos such an order for conditional registration are these. I would accept straight away that such conditions limit a general practitioner in his or her practice, but such a condition has not hitherto prevented Code A from such practice. I am not entirely clear whether or not such an undertaking originally lapsed or whether some such undertaking has been in place at all times, but I have been shown today by my learned friend Code A a document of October 2002, headed on AFareham and Gosport Primary Care Trust@ paper which contains a form of undertaking; it is a voluntary undertaking and it may be convenient if at this stage you had that document available to you. (Handed.)

Code A D1.

Code A That you have in front of you a file note of a meeting held on the 9th October 2002 a meeting at which Code A was present when Code A in the second paragraph confirmed that Code A s offer of a continued voluntary ban on OP prescribing. This was agreed despite the fact that the GMC does not require it. It was pointed out that this has implications for the remaining practice members. Code A had been advised by her medical defence society to carry a single vial of diamorphine in case she was presented with an absolute medical emergency. It was confirmed that the above arrangement does not, in practice, compromise the patients= safety in her practice list, thanks to the partners in the practice for accepting and dealing with this voluntary restriction. Code A agreed her voluntary restriction covers opiates. Benzodiazepines would be prescribed strictly within BNF guidelines.@ It goes into monitoring arrangements with which I do not think is pertinent at the moment unless my friend wants me to read them out. So it would appear that there is in place some form of voluntary undertaking on the part of Code A The obvious point I will take on behalf of the Council is that it is of course an unwritten undertaking of no particular duration and capable of being withdrawn at any time and incapable of enforcement by the General Medical Council. It is not something which would come to the notice of anybody making enquiries in relation to Code A whereas conditional registration has that important and significant effect. That is a matter which I am conscious you will be perfectly familiar with as being of importance,. Now that the Council for Regulation of Health Care Professionals has appealed a number of cases concerning doctors in the course of the past 12 months or so, we can see the importance that is attached to the public availability of information so that the public can be confident that those things that ought to be able to be known by the public are known by the public, whether they be prospective employers or prospective patients. This sort of undertaking is unfortunately not in any way known to any such persons.

I accept therefore that there are limitations on Code A s practice, but they are not presently enforceable. I accept, secondly, that the draft condition which I would submit is appropriate in this case can potentially disadvantage patients of the general practitioner, particularly a patient in need of such medication who will come under the aegis of another registered

A medical practitioner, but it is clear in this case from what we have seen in the papers that Code A Code A is supported by other medical practitioners in the partnership and that has been obviously important to the patients.
Can I say as a footnote that I am not suggesting that there should be any arrangement in relation to prescription or administration under an appropriate supervising medical practitioner. You will understand from the way I put it that it would be envisaged by the Council that this is a lady who should be able to continue in practice and that I do not rule out
B some such possibility. What I am concerned about is that there must appropriate protection in all the circumstances of the case.

The third point that I would make is that I would accept that a condition such as I would propose adversely but temporarily affect a doctor=s reputation.

C Fourthly, the duty of the GMC is to guide and regulate doctors while protecting the patients and the public interest. Therefore what you are concerned with today as in all these cases is to achieve a proper balance between the competing interests of patient protection, protection of the maintenance of the reputation of doctors in the profession and good practice, and, of course, the interests of the doctor herself.

D These, as you will know only too well, are spelt out in section 41A of the 1983 Act as amended and I hope I will be forgiven if I simply go to those opening words of section 41A. I do it in part also because my submission to you today B I endeavoured to forewarn my friend Code A by making sure that he had a copy of the case which I was going to refer to and refer him to B is that a test which has been propounded in past cases and I believe has probably been propounded in this case, at least once, is not in truth the proper test to be applied by an interim orders committee. Section 41A provides

E AWhere the Interim Orders Committee are satisfied that it is necessary for the protection for the protection of members of the public or is otherwise in the public interest or is in the interests of a fully registered person, for the.registration of that person to be suspended or to be made subject to conditions, the Committee may make an order ....@

F either suspension or registration being conditional with such requirements for a period not exceeding 18 months as the Committee thinks fit to impose. So you have a very very wide discretion in terms of conditions that you think fit to impose. Going back to the opening words it is plain that nothing is said in the Act as to what is the test to be applied. The verb Ayou must be satisfied@ is plain, you must be satisfied in relation to three alternatives which are not exclusive, they can overlap and be accumulative.

G What then is the test? The test which has been applied in the past by many interim orders committees was one which I understand was propounded by a legal assessor on an inaugural training day when matters came to be considered in the light of the problems which had been thrown up by the fact that there had been inadequate powers to deal with interim protection of patients and doctors when the PPC could only impose interim conditions if there was a reference to the PCC. So in came the amendment rules and the test which I understand has been consistently applied has been this that there should be cogent and credible prima facie evidence which if proved could amount to seriously deficient performance of serious

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professional misconduct or impaired fitness to practice by reason of a physical or mental condition such that the doctor=s registration could be restricted by interim suspension or conditions until matters are resolved.

The difficulty about that test is that, as you will know from experience, as many of your colleagues will know, in many cases a doctor who has been arrested and charged B I use that by way of example, this is a lady who has neither been arrested nor charged at an earlier stage despite some three years of police investigation C with a very serious criminal offence, perhaps relating to patients, perhaps not, the police will probably have made no evidence available to the General Medical Council apropos that document or the evidence which is the subject of the charge. Therefore there would like as not be no evidence, not prima facie evidence, but no evidence in relation to that doctor and yet of course if it be a very serious matter which potentially affects the capacity of that doctor=s safety to behave as a doctor then the problem is that the statute requires that you consider whether it is necessary for the protection of members of the public or patients and others which was otherwise in the public interest that that doctor be suspended or made the subject of conditions. That test I do not understand has been substantially considered in the case law, but in the case of Dr X which I would ask for that to be made available to you if possible, and I know it was made available to your legal assessor yesterday at my request, the Court consisting of Code A Handed)

Code A This will be C2.

Code A The court had to consider the case of Dr X who was applying to quash and I am looking at paragraph 1 now an order of this Committee made on the 2nd March 2001 following an oral hearing on that day. A

"The IOC ordered that the claimant=s registration as a medical practitioner should be suspended with immediate effect for a period of 18 months. It was further ordered that the suspension should be reviewed by the IOC at a further meeting to be held within six months.

The claimant is a general practitioner of premises in the south east of England. Allegations of indecent assault are made against him by two of his nieces (now aged 15 and 13 years). Their father complained to the Social Service Department of the County Council and the Health Authority also became involved. The GMC were informed of the allegations. On the 28th February 2001 the claimant was charged by the police with six counts of indecent assault. He was granted bail subject to conditions. By virtue of Articles 3 and 10 of the Medical Act 1983 Amendment Order 2000 the 1983 Act was amended by the addition of Committee and a new section.@

I have already read you section 41A so I do not need to read it again and subsection 10 we do not need to be concerned. Then paragraph 5:

A The IOC has its origins in the Amendment Order. Similar, though somewhat different, powers were formerly exercised by a different committee of the GMC. At the hearing on 2nd March 2001 both the claimant and the GMC were represented by counsel. The hearing was conducted by a committee of five members advised by a legal assessor. Some of the

A argument before the Committee turned upon the possibility of an interim conditional registration. It is common ground that it is not open to the court to take that course upon this application. The power of the court, subject to its power under section 41A(10)(c) is either to quash or to uphold the order of the IOC.@

From paragraphs 6 - 10 is concerned with the court and I can pass over the courts position and we come to paragraph 11:

B

A The determination complained of was:

A.... the Committee has carefully considered all the evidence before it today.

In accordance with Section 41A of the Medical Act 1983, as amended, the Interim Orders Committee has determined that it is necessary for the protection of members of the public, is C in the public interest and is in your own interests to make an order suspending your registration, for a period of 18 months with effect from today.

In reaching the decision to suspend your registration the Committee has concluded that there is prima facie evidence of indecent behaviour that, if proved, would seriously undermine the trust the public is entitled to place in the medical profession. The Committee has considered D the submission made on your behalf that if an order were to be imposed, interim conditions would adequately protect patients. However, after considering all the circumstances in the case, and having regard to its duty to protect the public interest, the Committee has determined that it must suspend your registration.@

I hope I will not need to read all of those. In paragraph 14 five of the charges related to one girl and the sixth related to the younger girl.

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We come to paragraph 15:

A Code A who appears for the claimant before this court, also appeared for him before the IOC, and accepted, as in my judgment he had to accept in relation to the charges: AThey are plainly very serious and the doctor is well aware that they are, if proved, extremely serious, and if accepted by a jury in a criminal court of trial they are likely to result in a F sentence of imprisonment and further conduct proceedings@. It is clear that the allegations have been considered by representatives of the relevant local authorities and by the police, whose code of practice provides that before criminal proceedings are brought there must be Aenough evidence to provide a realistic prospect of conviction@.@.

Can I interpolate that. It is plain that the court was giving weight to the fact that Dr X had been charged. They would clearly have given less weight, as you clearly must give less G weight, to the fact that here Code A has not been charged. They proceeded however on the basis that the police would not be proceeding to charge unless there was evidence and therefore although there was no evidence in front of the IOC none the less the fact that there was a charge was a relevant matter which should be taken into account and could properly form the basis of the IOC,

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Can I pass over paragraph 16. Paragraph 17 is informative but not relevant, so I move to paragraph 17:

A Code A also makes the point that the IOC have relied upon all three grounds in section 41A(1) and have done so cumulatively. If any of them fail, and Code A submits that the concept of protection of members of the public and the concept of the interests of the claimant *himself must fail, then the entire case falls. I say at once that I do not accept that submission.* Based, as it is, on the wording of the second paragraph of the determination, it appears to me that, provided one of the criteria was satisfied, the fact that one or more of the others was not satisfied does not, in the circumstances of this case, invalidate the conclusion of the Committee. The wording does not suggest that the satisfaction of all three criteria were, in the view of the Committee, necessary to a conclusion that an order should be made against the claimant.

The second submission is that the Committee were not considering, as the Committee in some of the cases cited were considering, a case where there was a conviction in a criminal court. In this case there is only an allegation or a series of allegations. It is not correct Code A submits that, even if the allegations are serious, as he has to accept those in this case are, it was appropriate in present circumstances for the IOC to make an order on the mere making of an allegation. He submits that the fact that the police have decided to charge the claimant makes no difference. The Committee must not be permitted to approach its work on the basis that the police would not have charged the claimant if had not done it. That approach, Code A Code A submits, is quite contrary to legal principle. Code A draws attention to the difficulties facing a defendant before the IOC in circumstances such as the present. There are obvious constraints on calling evidence before a Committee when criminal proceedings have been commenced. I accept that there may well be difficulties, but the IOC must consider the case on the basis of the material which the GMC and the defendant see fit to call before them.

I am far from criticising the claimant and those who represented him for not in the circumstances of this case calling evidence. I do not leave the point however without stating that there could be cases in which material placed before the Committee when criminal charges were pending might, having regard to the duties of the Committee place allegations of criminal conduct in a very different light from that in which they might otherwise have appeared.@

Just interpolating there on paragraphs 18 and 19 Code A can go further than even Dr X. She can rightly say AI have given evidence before an earlier IOC@ and I will draw your attention to that evidence. She can say AI have not been charged.@. She can even say AI have not been interviewed, therefore we are concerned only with the possibility of allegations being made against me of a criminal character.@ That is also entirely true. That is why I say she can say it. She can no doubt through Code A will say it. The question is what is the test? Before I come to what I suggest a proper test should be can I just continue on at paragraph 20. AThe third submission is as to lack of reasons.@ That is formative but not relevant to my point and I pass over that paragraph and paragraph 21, and can I come to paragraph 22:

A When pressed on the point, Code A put his third submission rather as a lack of consistency by the Committee, or of disparity between its decision in this case and its decision in other cases. There has been some reference to other decisions of the Committee. I acknowledge the constraints which rest upon both parties in giving particulars of other cases. However, it is essential, as Code A put it, that each case is considered upon its own particular circumstances.@

B I would parethenthally if I may underline that sentence. Code A s case is to be considered in its special and you may think unusually prolonged and difficult circumstances, its own particular circumstances.

A Reference to other cases which Code A rightly accepts would not be binding upon the Committee is of limited value. Moreover, on the limited information which has been provided by the parties, I am far from satisfied that there can be said to be any inconsistency C between the decision taken by the IOC in this case and its decisions in other cases. It is not necessary for present purposes to give details of those other cases.

23. Reference has been made to Article 6.1 of the European Convention. In my judgment in present circumstances that adds nothing to the duties already required by English law. I see no merit in the submission that the decision of the IOC fails either on the ground of lack of D reasoning or by reason of disparity between this and other decisions.

24. I have referred to the limited nature of the material which was before the IOC. It was for them to examine the material before them with care. It is plainly a worrying situation when a professional man may be suspended on the basis of allegations of criminal conduct which, as yet, are untested in a court of law. I cannot however accept that the power to suspend by way of interim order provided in section 41A must not be exercised because the allegations are E untested in court. Nor, in my judgment, can it be said that the exercise of the power to suspend was inappropriate because the conduct alleged was not towards patients of the claimant.

25. The allegations in this case are undoubtedly serious. They are of offences against the person. Whether or not they are eventually proved it cannot be said that they plainly and obviously lack substance.@

F That is another way in which one can test the matter, ,is what is being put before you something which plainly and obviously lacks substance?

AThey involve an alleged breach of trust towards vulnerable young people. The alleged offences have an obvious impact upon the fitness of the claimant to have that intimate contact with patients which is a necessary part of his duties as a doctor. That being so, it cannot in G my judgment be said that the IOC erred in law in reaching the conclusion they did. They were entitled in their discretion to do so on all three grounds in section 41A in my judgment, especially having regard to the breach of trust alleged.@

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What do I submit is the appropriate test if it be not cogent and credible evidence etc> The formulation which I would respectfully submit would be this that if you are satisfied B I use the same verb - (a) in all the circumstances of this particular case that there may be impairment of Code A s fitness to practice which poses a real risk to members of the public, or may adversely affect the public interest or her interests (b) after balancing her interests and the interests of the public that an interim order is necessary to guard against such a risk then the appropriate interim order should be made. Such a test is not confined to evidence; it plainly permits consideration of a reliance on materials such as third party reports. In my submission it is implicit in the reasoning of the court in Dr X=s case that that is a more appropriate test if not the test which the court applied.

In terms of the application of that test to this case my submission is that the circumstances should satisfy you that there may be such impairment and that it does pose a real risk potentially to her patients, members of the public and I also submit as a separate consideration that if no conditions are made and the doctor in her circumstances is permitted to practice with no more than a voluntary undertaking that also may adversely affect the public interest by which I refer to the reputation of the profession, and the need of the public to have complete trust and confidence in registered medical practitioners.

I will add this in relation to public interest that confidence would be undermined if upon due enquiry, whether on our website or by telephone or otherwise, nothing was shown which in any way restricted Code A to practice in all the circumstances of this case.

Clearly I have tried to build into that test the proportionately which is essential in respect of Code A s interests, namely, balancing the interests of practitioners with the interests of the public. That is the test.

As I understand it the difference between us, it being agreed suspension is plainly not appropriate, which I noticed was what was originally asked for on the first hearing, is some condition on the registration in the public interest, but it will permit Code A to continue in practice.

Those are the preliminary submissions which I wish to make before going to the chronology, so can I go to the chronology. If I leave anything out because I am conscious that my learned friend may have access to a few more documents than do I please will he say so so they can go in chronological and present a better picture. Can I add a footnote to the first block in this matter, February to October. That is the period of the five patients. The period of the police investigation has been said as you will see by Code A to be between January 1996 and November 1999, but actually that seems to me to be wrong berceuse it is plain from the document which they have just produced to us, which I have not yet seen, or my friend has seen or Code A has seen, the notes that come with it, the case of a patient called Code A which is at page 490 in the bundle, covers the end of the year 1993 and the beginning of the year 1994. SO we are concerned with a long period in which Code A Code A was a part-time Code A at those particular wards in Gosport.

A She resigned from part-time employment and continued in general practice. I have given the page references where I have noted them and they were obviously available; in some instances I have simply taken it straight from what she has said and that comes from her own evidence to an earlier Committee. I am not going to turn up the pages unless anyone wants me to do so.

B On the 27th July 2000 at page 9 you have the letter which as I understand it first informs, though I have seen in an earlier transcript it seems to have been said to be later, but this is a letter of the 27th July 2000 where Hampshire Constabulary informed the GMC fitness to practice directory of concerns relating to Code A and a patient called Code A She was the subject of an allegation that she had been unlawfully killed as a result of Code A medication at one of the wards, so it was put as a very serious allegation back in 2000. Unsurprisingly, it led to a reference

C to this Committee on the 21st June 2001. That you will see in my note of the chronology said ANo transcript available@. You of course have that available to you and I will give you the reference to pages 553 to 562. It would be helpful just to have a quick look at one or two matters there. It only concerned the patient Code A Code A it was not concerned with any other patients. You will see if you turn to page 554 at the top of the page Code A on behalf of the Council opened it in her second sentence that the nature of the case as set out in summary was one of unlawful

D killing and talks about the police investigation continuing. I am going to pass over to page 4 at letter E and you will note there that Code A submitted on behalf of the Council that although Code A had not been charged or interviewed or arrested that it was her submission that in her view it would not be appropriate to consider conditions on the doctor=s registration, in other words it had to be suspension, and you will see contrary submissions being advanced by Code A who appeared all the time although he is not available today and at page 555 at letter C you will note he

E says AThis case may have been brought prematurely@ and he suggested it should not have been brought at all and so on and he goes into the details and says AAs far as the doctor=s present position is concerned she does not continue to work with the hospital.@ Can I go onto the test which seems to have been applied at page 561 the legal assessor gave advice and you will see at D

F AIt is necessary to find the evidence before it amounts to a prima facie case supporting interim action on one or more of the grounds that I have just referred to.@

The determination of the Committee on page 562 AThe Committee have determined that they are not satisfied that it is necessary for the protection of members of the public ...@ and so on. We can put that document away and perhaps not come back to it, can I say the last page there was the expert review which was missing which you may have noted in going through the extra pages which went with Chief

G Superintendent Watts statement had not been provided until yesterday for which we apologise , but it has been found and now provided.

So much for the first Interim Orders Committee hearing.

There was therefore as you can see at that stage no independent expert opinion. At pages 19 to 52 by a report of the 20th July 2001 you will see Code A

H report. Can I interpolate before looking at this and the next two reports, I would

accept straight away that you would only in the most exceptional circumstances make an order on material which had been decided not to justify making an order in the past by earlier interim orders committees, whether you had been a member of it or not, it would only be in the most exceptional circumstances. Clearly a relevant circumstance was the test which was applied in the other cases and if I persuade you that in fact the prima facie evidence test was not the right test then it would be right I would suggest that you should revisit the totality of the evidence and apply if you are so satisfied in the light of your legal assessors advice is the appropriate test. I do suggest here that it is right that you must look at the totality, you must look at all the circumstances, that is what Code A indicated was appropriate and we need now to consider in the interests of Code A , the interest of all the patients, her patients and other patients of the practice and other members of the public for whom she might prescribe or administer, and equally we must consider the interests of the medical profession and public confidence in it, looking at the totality. I am not going to go through everything at the same pedestrian pace which might be appropriate if you have not seen much of it before, but I understand one member of the committee has not been involved in any of the previous hearings otherwise everybody has had some involvement with this case at some earlier stage, not including the legal assessor. I come freshly entirely as well. If I take matters either too fast or too slow I would ask you to indicate that to me and I will change the pace accordingly.

Code A report begins at page 19 and you will see in the synoposis on page 19, he was considering the case of Code A says this at paragraph 1:

A At the age of 91 years Code A was an inpatient in Daedalus ward at Gosport War Memorial Hospital. A registered medical Practitioner prescribed the drugs diamorphine, haloperidol, madazolan and hypascine for Code A These drugs were to be administered Subcutaneously by a syringe driver over an undetermined number of days. They were given continuously until Code A became unconscious and died. During this period there is no evidence that Code A was given life sustaining fluids or food. It is my opinion that as a result of being given these drugs Code A death occurred earlier than it would have done from natural causes.@

There is his synopsis to be seen in the context of the earlier IOC hearing which in the second hearing has made no order having seen that material. I will bring you to that in due course.
Paragraph 2.5 on page 21:

A This report has been presented on the basis of the information available to me - should additional information become available my opinions and conclusions may be subject to review and modification.@

I will pass much of the material here and can I draw your attention in paragraph 4.9 page 25 to some standard which is to be found in the majority of the patients with which we are concerned that Code A said in the notes AI am happy for nursing staff to confirm death.@

A

Then on paragraph 5 page 29,

A Code A wrote the following drug prescriptions for Code A ....@
And you have the detail there, we have Oramorph 11th August four hourly and then diamorphine at a dose range of 20 - 200mb to be given subcutaneously in 24 hours. A number of people have drawn attention to that rate, it is a very large range, and it has been subjected to some criticism as being undue, you may think when you see the evidence, which I will draw to your attention of Code A circumstances there is very really little consultant supervision and with precious little and sometimes know medical support at all= so that effectively the circumstances in which she was working was most undesirable by any standard and she was incredibly hard pressed and much will have turned on the circumstances which she has described in her oral evidence as to what was necessary in order to try and provide proper attention to those patients. I am trying to present what I understand to be the picture which may be true, it may be false, but it is one that one can see in the papers. Then hyacine, midazonlan, then haloperidol. On the 12th August oramorph in 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly.

B

C

Then on the 18th August, moving on, diamorphine with a dose range of 40- 200 mg and haloperidol. Then on the 18th, 19th, 20th and 2lst August Code A was given simultaneously and continuously subcutaneously diamorphine 40mgs and haloperidol 5mgs and midazolam20 mgs during each 24 hours.

D

If I can go to the conclusion on page 32

A Code A died on Code A , while receiving treatment on Daedulus ward at Gosport War Memorial Hospital

E

Some four years earlier on 3rd August 1994 Code A had become resident at the Glen Heathers Nursing Home.

Code A had a confused state that after December 1997 had been aggravated by the loss at the Glen Heathers Nursing Home of her spectacles and both of her hearing aids.

F

On 29th July 1998 Code A developed a fracture of the neck of her right femur, thighbone, and she was transferred from the Glen Heathers Nursing Home to the Royal Hospital Haslar, Gosport.

On 11th August 1998 and having been seen by a consultant geriatrician Mrs Richards was transferred for rehabilitation to Daedalus ward at Gosport War Memorial Hospital.

G

At that time Code A recorded that Code A was not obviously in pain but despite this Code A prescribed Oramorph to be administered orally four hourly

At that time also Code A prescribed for Code A diamorphine hyoscine and midazolam. These drugs were to be given subcutaneously and continuously over

H

periods of 24 hours for an undetermined number of days and the exact dosages were to be selected from wide dose ranges.

Also on 11th August 1998 at the end of a short case note Code A wrote AI am happy for nursing staff to confirm death.@

It is noted that although prescribed on the day of her admission to Daedalus ward at Gosport War Memorial Hospital these drugs, diamorphine, hyoscine and midazolan, were not administered at that time.@
It then goes through the sequence and I have taken you through the prescriptions so far. At paragraph 7.10 he said:

A There is no evidence that Code A although in pain had any specific life threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.

Despite this and on 18th August 1998 Code A while knowing of Code A sensitivity to oral morphine and midazolam prescribed diamorphine, midazolam, haloperidol and hyoscine to be given continuously subcutaneously and by a syringe driver over periods of 24 hours for an unlimited period.

Neither midazolam nor haloperidol is licensed for subcutaneous administration.

It is noted however that in clinical practice these drugs are administered subcutaneously in the management of distressing symptoms during end of life care for cancer.

It is also noted that Code A was not receiving treatment for cancer.

There is no evidence that in fulfilling her duty of care Code A reviewed appropriately Code A clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.@

Then at 7.16
Code A recorded that death was due to bronchopneumonia.

It is noted that continuous subcutaneous administration of diamorphine, haloperidol, midalam and hyoscine to an elderly person can produce unconsciousness and death from respiratory failure associated with pneumonia.@

Then we come to his opinion. I would invite you to read all of this to yourselves. Can I say you find the conclusions at 8.10 and 8.11 perhaps deserving of particular attention. (Pause to read)

You will see that it was his opinion that Code A and I am looking particularly at paragraph 8.11 death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine and other drugs. That was our starting point in relation to the medical evidence none of

which was available at the first hearing. It was part of the material which was put before the second hearing on the 2lst March and led to the making of no order.

The next report was that from Code A but before we see Code A report you will note at page 13 of the bundle a letter from the Hampshire Constabulary that there was insufficient evidence to support a viable prosecution against Code A concerning Code A That was in relation to the unlawfully killing of Code A Code A based upon the allegation of her two daughters. I am not going to take you through those statements. My learned friend can call your attention to any part of it which he feels is of assistance to you, but clearly those two ladies have made allegations against a lot of people including Code A in relation to the allegedly untimely death of their mother.

I pass on therefore to Code A report beginning at page 53. He considers the case not just of Code A but also those of other patients. He describes the use of opioid analgesics which I will not read to you. He then turns to Code A Code A at page 54:

A Code A was known to suffer with depression, Parkinsons disease and cogitive impairment with poor short term memory.@

Then can I go to Comments:
A All the prescriptions for opioid analgesics are written in the same hand, and assume they are Code A prescriptions although the signature is not decipherable. Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two does of oral morphine, the 24 hour dose requirement of Diamorphine could not therefore be established. The dose of diamorphine prescribed gave a tenfold range from 20mg to 200mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Code A on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication.@

Code A you will see is a patient who has been categorised when you come to Police Code A statement as a category 3 case which is to say B and I refer to page 460 and 461 B a case where patient care in respect of these cases has been assessed as Anegligent, that is to say outside the bounds of acceptable clinical practice.@ That is the definition. The reference of Code A being so categorised is at page 465. So what we do not have to day is a statement from the doctor or doctors who have made that categorisation, it is undoubtedly new information which was not available to any earlier committee. What we do not have today is the notes of papers or documents from which that categorisation has been made, but none the less it has been thought appropriate to bring this matter back to an interim orders committee, clearly matters have moved on, but they are still on going.

A Code A is considered on page 55. He notes in the latter part of the first paragraph that the dose of 30mgs was given on the 20th August of Midazilam apparently by Code A and the patient was given another 30mg of Diamorphine on the Code A and died later that day. The Comment was:

A There was no clear indication for an opioid analgesic to be prescribed and no simple analgesics were given and there was no documented attempt to establish the B nature of her pain. In my view the dose of Diamorphine that was prescribed at 30mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the diamorphine prescription gave a tenfold range from 20mg to 200mg in 24 hours.@
Code A is a case where it is said by the police in their statement at page 465 ANo further police action to be taken in respect of this investigation. The medical C records available are not sufficient to enable an assessment.@

Code A page 55, was none to suffer alcohol abuse with gastritis hypothyroidism and heart failure. Like many he had fractured bones, a fractured humerus in his case. Turning to page 56:

A A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16th October D again in Code A s handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of diamorphine was given on 16th October and the nurses commented later that the Apatient appears comfortable.@ The dose was increased to 40mg the next day when copious secretions were suctioned from Code A s chest.@

The patient in this case died on the Code A Comments:

E A Code A was clearly in pain .from his fractured arm at the time of transfer to Dryad ward. Simple analgesics was prescribed but never given there was an entry earlier in the episode of care that Code A had refused paracetomol. No other analgesia was tried prior to starting morphine. Code A had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in diamorphine. Once against the diamorphine F prescription had a tenfold dose range as prescribed.

It is clear that Code A s condition suddenly deteriorated probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate. A Do Not Resuscitate decision had been made by Code A on 29th September.@

G Now that needs to be contrasted with this that that assessment was in effectively an exonerated assessment you may think in relation to Code A but if you turn to page 465 you will see that it has been categorised as category 3.

The next patient was Code A and known to suffer with hypertension, ischaemic heart disease with heart failure and paroxysmal atrial fibrillation, depression, episodic confusion and had sustained a minor stroke in the past. The comments page 57: H

A Code A had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. When she was transferred to Dryad Ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding her symptom control and she was started on opioid analgesia.in my view inappropriately following her spitting out of medication and she was given a topical B form of an opioid analgesic, fentanyl. A decision was taken to start a syringe driver because of her distress, this included Midazolam which would have helped her agitation and anxiety.

The prescription for subcutaneous diamorphine infusion again showed a tenfold range from 20 mg to 200 mg. It clear that her physical condition deteriorated rapidly and I C suspect that she may have had a stroke from the description of the nursing staff shortly prior to death.

CONCLUSIONS: I felt that the nursing records at Gosport War Memorial Hospital were comprehensive on the whole. The reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath, or cough requiring relief. In several of the cases concerned oral D morphine was not given for long enough to ascertain the patient=s dose requirements, the reason for switching to parenteral diamorphine via subcutaneous infusion was not documented and the prescription of a tenfold range 20 mg to 200 mg of diamorphine on the as required section of the drug charge is in my view unacceptable. In my view the dose of diamorphine should be prescribed on a regular basis and reviewed regularly my medical staff in conjunction with the nursing team. There was little indication why the dose of diamorphine was increased in several of the cases and the E dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Code A and Code A are necessary to confirm the identity of the prescribers and doctors making entries into the clinical notes.

I believe that the use of diamorphine as described in these four cases suggest that the F prescriber did not comply with standard practice. There was no involvement as far as I could tell from a palliative care team or specialist nurse advising on pain control. I believe these two issues requires further consideration by the Hospital Trust.@

That was the view of Code A a consultant physician and geriatrician.

Then we have the opinion of Code A concerning the five patients, not four, pages 59 G to 97, he is a Professor of Pharmacology of Old Age in the Code A Pharmacology in the Code A and a consultant physician in Clinical Pharmacology at Code A. He then reviews the case of Code A from pages 62 through until 71. I am only going to draw your attention to paragraph 2.29 on page 70 under the heading Appropriateness and justification of the decisions that were made@.

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A A There were a number of decisions made in the care of Code A that I consider to be inappropriate. The initial management of her dislocated hip prosthesis was sub-optimal. The decision to prescribe oral morphine without first observing the response to milder opiate or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate.@

B The under Summary:

A Code A was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedualus ward there was inappropriate prescribing of opiates and sedative drugs by Code A These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death.@

C Code A he considers from page 72 and following. At paragraph 3.10 at page 74 second sentence:

A I consider the decision by Code A to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate particularly when there was a clear instruction by Code A that he should be prescribed intermittent underlined instruction doses of oramorph earlier in the day. I consider the undated prescription by Code A of subcutaneous diamorphine 20-200 mg/24 hr prn, hyoscine 200-800 microg/24 hr and midazolam :20-80 mg/24hur to be poor practice and potentially very hazardous. A

D

E He at paragraph 3.14 was concerned by the note which we have seen in relation to a number of the patients that Code A was happy for nursing staff to confirm death. Then at paragraph 3.16 he considered it very poor practice that midazolam was increased from 20 to 60 mg every 24 hours on the 23rd September. Then under duty of care issues at page 77 under 3.23 the last sentence:

A In my opinion this duty of care was not adequately met and the denial of fluid and diet and prescription of high dosage of diamorphine and midazolam was poor practice and may have contributed to Code A s death.

F

In summary although Code A was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer. Code A and the ward staff appear to have considered Code A was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of subcutaneous diamorphine, midazolam and hoscine by Code A was in my view reckless. The dose increases undertaking by nursing staff were inappropriate if not undertaken after medical assessment and review of Code A I consider it highly likely that Code A Code A experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these

G

H

drugs most likely contributed to the death through pneumonia and/respiratory depression.@

Code A is considered at pages 70 to 82. Can I go to the summary at page 82:

AIn my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death. However, Code A was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative sand opiate drugs.@

Then Code A is considered and the conclusion is at page 87

A Code A was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion, inappropriately treated with high does of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.@

Then Code A the summary at page 92:

A Code A was a frail elderly lady with probable carcinoma of the bronchus who had been deteriorating during the two weeks prior to admission to Dryad ward. In general I consider the medical and nursing care she received was appropriate and of adequate quality. However, I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Code A on the 3rd March. In my view this was an inappropriate potentially hazardous prescription. I would consider it highly likely that Code A experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia.@

Then he concludes at pages 93 and 94. And at 7.3:

A My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease, lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of old people with rehabilitation needs.

7.4: In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used

only when the patient is unable to take medicines by mouth, has malignant bowel obstructions or where the patient does not wish to take regular medication. In only one case were these criteria clearly fulfilled, i.e. in Code A who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive does and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

7.5 Review of the cases suggested that the decision to commence and increase the dose of diamorphine and sedative drugs might have been made by nursing staff without appropriate consultation with medical staff. There is a possibility that prescriptions of subcutaneous infusions of diamorphine midazolam and hyoscine ay have been routinely written up for many older frail patients admitted to Daedalas and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. 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 the ward. Closer enquiry into the ward practice, philosophy and individual staff=s understanding of these practices would be necessary to establish whether this was the case. Any problems may have been due to inadequate training in management of older patients. It would be important to examine levels of staffing in relation to patient need during this period as the failure to keep adequate nursing records could have resulted from under staffing of the ward. Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards. My review of Code A medical notes and her statement leads me to concluder she is a competent thoughtful geriatrician who had a considerable clinical workload during the period the above cases took place.@

7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Code A were not adequate at the time these patients were admitted.@

There are then the appendices which I do not need to turn to.

On the 6th February 2002 the Crown Prosecution Service decided not to institute criminal proceedings concerning Code A and they disclosed their papers to the GMC, that is on page 15 and 16.

On the 2lst March 2003 we had the second interim orders committee hearing. You have the partial transcript in your earlier papers and you now have the full transcript available.. The submission was that Code A should not be suspended but that her registration should not remain unrestricted and that the voluntary arrangements should be formalised so that was to be found on page 4 of the transcript. I will take you to the full transcript if that was thought helpful. I do not know whether you have had a

proper chance to consider it. I was presently minded not to take you to it, and I have taken you thought what much would have then been said.

Code A We have all read it.

Code A Can I move on from the 2lst March emphasising that what I have just been drawing your attention to has been considered query with the appropriate test by an earlier interim orders committee and which resulted in no order being made.

You see at the top of the second page of my chronology I say at the end of March 2002 Code A s undertaking to the Health Authority not to prescribe opiates or benzodiazepines ceased., see pages 453 and 454. That was taken from the submissions made on her behalf by Code A her counsel and perhaps we ought to look at it because I anticipate one of the matters you will want to know what is the true state of affairs and what has been the position in the recent past. At H Code A said

A The condition to which she agreed with the Health Authority B that she would not prescribe opiates or benzodiazepines - lapsed at the end of March of this year because there was initially a time limit put on it and the health authority did not see fit to invite her to renew that undertaking. So far as the circumstances changing since the last hearing before the IOC 21 March 2002, I think that is the only change, I am sorry condition that she did not prescribe benzodiazepines or opiates was lifted by the Health Authority.@

It seems there was a slight change in instruction of the understanding. I am not in a position to assist you further with that. I have no document to assist further all I have is the document produced at D1 today, but clearly there was in October of that year an informal undertaking in the respects you have seen. So on the 11th July 2002 the rule 6(3) notice was provided to Code A If we could look at that briefly. You will see there were a number of headings to the allegations that in relation to Code A item 2, Code A item 3, Code A item 4, Code A item 5, Code A item 6, there were respectively effectively inappropriate prescription, particular diamorphine, hyoscine and midazolam, inappropriate administration of the treatment of those patients should be the subject of a proper inquiry by the PCC for the reasons there set out. I am not going to go into the detail because it is repetitious. That rule 6(3) notice duly led to a reference. But there was a detailed reply from the medical defence union on behalf of Code A at pages 404 to 412. You will see that in essence what was said on her behalf was the substance of what she then gave by way of oral evidence to the third committee hearing. Since I am going to take you to that in some detail I will not take you through this, but clearly I will put it this way that what was being advanced on her behalf was that there was seriously deficient support, that she was seriously pressed to cope, she was doing everything she could to cope and that the treatment of these patients was appropriate. In addition to that she was saying that such were the pressures it meant that she could not keep proper note and that therefore what was the true condition of those patients is not adequately described in those notes, and therefore the problems were acute. I hope that is a fair summary.

Code A There was a second IOC hearing in March 2002?

Code A What I have failed to do is to go to what she said in the earlier hearing, could I go to that, it is at page 413. Rather than read it out to you can I invite you even if you have read it before to reread pages 413 through to 429 so that what she has said on oath is in your minds when you come to make your decision. If you could do that now.

Code A Yes, we can do that, I am sure we already have that.

Code A Yes, I am sure you have, I just wanted to make sure that her side had been put fairly and squarely before you not just by my learned but by me.

Code A Very well, if you give us a moment to read it. (Pause to read) Yes, we have read it.

Code A To continue the chronology the matter came before the preliminary proceedings committee on the 29th August 2002 and it was decided that Code A s case should be referred to the Professional Conduct Committee; unsurprisingly the police investigations were still continuing some two years later. That hearing is still awaiting. There was notice given on the 13th September of a third hearing and you have a transcript of the third hearing at pages 437 to 455. You will see that Code A on behalf of the Council said at page 439: AIn other words what has changed in a sense is the fact that the matter is now being referred on to the PCC and the possibility of criminal proceedings has raised its head again.@ That was the way it was put, in other words not new medical evidence, but the referral on to the PCC and the continued police investigation. The view of the committee was at page 455

A There is no new material in this case .since the previous hearing of the Interim Orders Committee on 2lst March 2002. The Committee has reached this determination in the light of this and the legal assessor=s advice.@

The legal assessor's advice is at page 454 in relation to what he said in camera namely

AIn the light of the fact that there was no new evidence it would be unfair to the doctor for the Committee to consider the matter any further.@

The earlier advice I pass over at page 453.

Code A This might be a convenient moment to have a break.

(Adjourned for a short time)

Code A The next entry in the chronology is September 2002 to date, the police investigation continues, pages 458 to 460 AThe first papers of selected cases are likely to go to the CPS in December of this year or early 2005.@ I should add straight away if there is a sufficiency of evidence and you can see immediately that that is bringing in the police new evidence. You might like for your own assistance

just to have the complete chronology in this sense that D1 seemed to me to go in immediately after that block of September 2002, that is to say the file note evidencing the undertaking of Code A with the Gosport NHT 9th October2002.

Can I go to page 456 and following and to the statement of Code A Code A of the Hampshire Constabulary Criminal Investigation Department, senior investigating officer in respect of this operation, given a code name.

A An investigation surrounding the death of 88 patients occurring principally during the late 1990s at Gosport War Memorial Hospital. This investigation followed allegations that during the 1990s elderly patients at Gosport War Memorial Hospital received sub optimal or substandard care in particular with regard to inappropriate drug regimes and as a result their deaths were hastened.

The strategic objective of the investigation is to establish the circumstance surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths

During the investigation a number of clinical experts have been consulted.@.

Code A reported on the death of Code A in 2000 and you have seen Code A statement and you have seen that statement of Code A

AThe Aforementioned reports has all been made available to the GMC. Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths and concluded that A a number of factors contributed to a failure of trust systems to ensure good quality patient care.@ Between September 2002 and May 2004 the cases of 88 patients including those named above at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxically, general medicine, palliative care, geriatrics and nursing. All the cases examined were elderly patients (79 to 99 years of age) their deaths occurring at Gosport War Memorial hospital between January 1996 and November 19999. A common denominator in respect of the patient care is that many were administered opiates authorised by Code A prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patient4s concerned, examining in detail patient records, and to attribute a score according to their findings against agreed criteria. A further group of cases were included in this review following a report by Code A commissioned by the Code A That report is confidential to Code A and may not be discussed further without his agreement.@

It is not before you, I have not seen it.

A The team of experts has scored the cases as follows.@ Just interpolating if I may the Code A says that these are against agreed criteria. We do

not have an appendix showing what the agreed criteria were or are, therefore the quality of our knowledge is imperfect.

Category 1 there were no concerns in respect of these cases upon the basis that optimal care had been delivered to patients prior to their death.@

Interpolating again you have behind this statement a number of summaries relating to patients, 40 in number, and you will see that 19 are referred to in category 2. Code A Code A on seeing the 19, looked at them, some of them did not appear to come into category 2, they appeared to come in to category 1, and that is why you only have 14.

A These cases are currently undergoing a separate quality assurance process by a medico-legal expert to confirm their rating. 19 of these cases that have been confirmed have been formally released from police investigation and handed to the General Medical Council for their consideration.@
So it is those of which you have a number behind the statement,.

AA number of cases have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.@

Category 3 patient care in respect of these cases has been assessed as Anegligent, that is to say outside the bounds of acceptable clinical practice@. The police investigation into these cases is therefore continuing. The five experts commenced their analysis of patient records in February 2003. That is my next block in the chronology. AAs part of the ongoing investigative strategy, since May 2004, a further tier of medical experts,in geriatrics and palitiative care have been instructed to provide an evidential assessment of the patient care in respect of in the category three cases.. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service. At the same time the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness suspect interviews, deal with exhibits, complete disclosure schedules and populate the major crime investigation AHolmes@ system a national police IT application used to record and analyse information relating to serious/complex police investigations. To date 330 witness statements have been taken and 349 officers reports created.. 1243 actions have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of .Hampshire Constabulary. A

Stopping there for the moment, what weight and what relevance does that have? If you are concerned with the test of prima facie evidence the answer is none at all. If we are concerned with the test which I have propounded them it is of some relevance. In exactly the same way, I would suggest, as a charge on Code A would be of some relevance, in exactly the same way it is reference from the PPC to the PCC is of some relevance. The question is what weight is attached to it. Plainly if it is of this scale

you give it the weight that you think that it deserves. It clearly falls less than and lower than an arrest or a charge, none the less I submit it should be given appropriate weight or suitable weight and in that context one needs not to look at the interests of Code A one must also look at the context that there is out there a large number of members of the public who are well aware of this investigation which is taking place, who are therefore very well aware that a doctor or doctors and nurse or nurses are under the scrutiny of the police, and that there have been allegations made of unnatural and untimely death brought about by lack of care.

How then do you balance this matter in that context? That must be for you to say. If my learned friend advances the old test as being appropriately then effectively I would say that is wrong as a matter of law. When we look at the section 41A test effectively you need to give it such weight as you think is right considering what is the public entitled to think in the present circumstances of what it knows in the context of what we know we know and what we do not know.

Back to the statement if I may.

A Whilst investigations will be fully completed in respect of all the category three cases a small number of sample cases have been selected and work is being prioritized around those with a view to forwarding papers to the CPS as soon as possible by way of expedition.@

It does seem as though in that sentence he is saying in terms there is a number of category 3 cases which will be referred to the Crown Prosecution Service.

A Timescales for this action are clearly dependent upon completion of expert review of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process. In the event that there is considered a sufficient of evidence to forward papers to the CPS it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.@

That sentence or those sentences appear to somewhat undermine the first sentence of the preceding paragraph

AI understand the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Orders Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee. in my view this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professionals involved in this enquiry. Police investigative interviewing operates from seven basic principles .....@

I am not going to read out aloud the next matter. Effectively it summarises why it is that they conceive it to be their public duty not to divulge to the General Medical Council the information which is available to them at this stage. There is clearly tension is there not between the protection of patients which the GMC provides and the protection of the patients which might derive from prosecutions. It is not

A concerned with the protection of patients, it is concerned with conviction of criminals and that tension does not seem to be very happily met when we have a three plus year investigation as we have here, which is still continuing, and plainly will be continuing into 2005. Again that is a reason I would submit why the test which I say should apply is likely to be right, rather than the earlier test.

B Turning over from the explanations providing an effective investigation he acknowledges on page 464 in the sixth line:

A As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case. I understand that there is a voluntary agreement in place between Code A and the Fareham and Gosport Healthcare Trust of November 2002....@

C I assume he is referring to this document at D1. and he quotes from that. My learned friend has shown to me today another document which I will not try and anticipate which relates to the prescription of drugs by Code A It does not come to quite that number but it matters not, but he doubtless be in a better position to explain the true state of affairs.

D AI have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim orders committee during September 2000.
Code A - this has been assessed as a category three case and is being investigated.
Code A again a category three case.
Code A - assessed as a category two case by the clinical team, this
E assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004.
Code A - no further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points:
1. There is no admissible evidence at this time of criminal culpability in respect of
F any individual.
2. The information adduced by the investigation thus far and the findings of the experts lead me to have concerns that are such that in my judgment the continuing investigation and the high level of resources being applied to it are justified.@

That concluding sentence is obviously important. What does it mean? In a sense I would suggest to you that it may be presumptuous for me to try and say what it
G means, but you may think one thing for certain is assured and that is this that a Code A in charge of the investigation amongst others of Code A Code A considers with the benefit of expert medical advice that the investigation should continue at a very high level. What relevance is that if you were to accept the test I have propounded its relevance is this is it not? It falls short of saying this lady is ever going to be charged, materially short of that, but it does say that there is a very real cause for concern and which this Committee and any member of the public, and
H of course you contain two quite specific members of the public as well as being

members of the public in your medical capacity, would if they knew that be entitled to say to themselves AWell, are we being properly protected against a person whose qualitive medical care is under such serious criminal investigation by either suspension or conditions?@ At the moment there are none, there is no suspension, no conditions. There have been voluntary undertakings. Are they sufficient? In my submission the answer is No and that in all the circumstances the test I have propounded brings in this matter. I recognise straight away it falls short of and is not an allegation in relation to a charge, a lady who has ever been arrested, or anything of the kind.

That brings me to the final documents as to how I approach this. For a reason which I will show you in a moment I am going to give them no great weight. Firstly, the documents which go with them, which I assume are in those piles over there and this pile here, a foot high, they are unseen by me appearing for the Counsel, they have only just been reproduced, they have not been seen by my learned friend Code A or Code A and I do not know the extent to which these documents are a reasonable analysis of those documents when done by counsel or solicitors with experience in this sort of field. Secondly, I do not know who has done this analysis; I do not know their qualifications, I do not know their expertise, and therefore it is a matter which is only to be approached with considerable reservations, very considerable reservations.

The third concern, it seemed to me on looking at the first of these cases Code A if you look over the page at 468 you will find that the prescriptions are normally done by persons other than Code A Say, for example, the 5th October, Code A is involved and he discontinues the diazepam. Code A is to rewrite MST. Code A Code A on the 7th October commences the syringe driver of 16 mls of diamorphine. On the 8th October Code A commences the second, on the 9th October we have a Code A and a Code A involved. Therefore to have assumed that where Code A is not mentioned that she was involved would seem to me to be an assumption which should not properly be made by you and I am not going to invite you to do it. Therefore I am only going to invite you to do it, and therefore I am only going to invite you to even look at five of these cases and they are Code A page 403, Code A page 406, Code A 490, Code A 499 and Code A 502.

I am going to take this simply because you may think the appropriate thing to do is to draw your attention to the matter and highlight any matter which seems to be potentially relevant with all the reservations which I have already expressed. At page 483, Code A is identified at the foot page on the 7th October, seen by Code A and Code A appeared to be in pain, she was a lady of some 70 years of age, one of the examples of the age group not being as we have been told.; also seen by Code A 9th August the nursing staff may confirm death. 17th October summary left arm elbow still very painful on movement. Code A seen X-ray from Haslar has requested.repeat x-ray. 18th October summary AAM very unsettled night appeared distressed and in pain. Syringe driver set up with 40mgs, diamorphine and midazolam 20 mgs over 24 hours. Fentanyl patch removed appears more comfortable. PM appears more peaceful and relaxed no pain on turning. Family seen by Code A and informed of poor prognosis. 19th October condition deteriorating chesty very bubbly. Code A died peacefully, verified by the nurses.

A

Code A expert view by the doctor who I cannot identify, perhaps I had better read all of it A

Code A was admitted to the Royal Haslar Hospital on 29th September 1996 after suffering a cerebrovascular acciden4t. She was transferred to the Gosport War Memorial Hospital on 3rd October 1996 for rehabilitation.

B

On 7 October 1996 Code A was felt to be in pain and was prescribed fentanyl patches. Code A was noted to be in a great deal of pain and the strength of the fentanyl patches were increased.

On 18th October following a very unsettled night when Code A appeared to be distressed and in pain a syringe driver was set up with 40mgs of diamorphine and 20 mgs of midazolam over twenty four hours.

C

Although Code A had a severe stroke which left her unable to swallow or speak, she was being tube fed. However she was prescribed rapidly escalating does of opioids without there appearing to be a comprehensive assessment made for her pain.

D

The experts note that she had an irrecoverable cerebrovascular and would have died soon in any event.@
You may think that that is a criticism, it is a criticism which potentially affects Code A Code A and her care in particular the pharmalogical care of these elderly ladies by an anonymous expert or experts.

Code A is the next one and the summary is at page 486. He was a 77 year old.

E

We are dealing with one of the latest ones, May 1990, he was admitted to Gosport Hospital on the 29th May as an emergency requested by Code A could no longer cope with him at home. Code A died .at five minutes past midnight Code A Code A and Code A informed. Death certified. by ....@ The expert review

A He was diagnosed with as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the

F

day of admission. He was then administered 10 mgs temazepam apparently which had been written up for him. The experts criticised the use of a small dose of temazepam in a patient who is cyanosed. They note though that Code A was already very.unwell.@

.Unfortunately when you look back at the cyanosis in the summary it is not there but it is referred twice in the expert review.

G

The next one is Code A and he is at page 490 and you see on the 28th December1993 Code A a gentleman of 80 was seen by Code A and oramorph 10mg 6 hourly prescribed was prescribed. On the 30th December the oramorph was increased and syringe driver commenced diamorphine 40mgs.... 31st December general condition deteriorates. On the Code A he died at 10-05. The summary in relation to him page 492

H

AIn December.1993 he was complaining of generalised pain and started on Oramorph. Code A notes that Code A went from little analgesis to oramorph 60mgs in twenty four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment. The experts review has determined that the treatment was sub optimal due to the high does especially midazolam. Cause of death was felt to be unclear by the expert team.@

Working with the material available to us that you may think does not subtract but adds to potential criticism of Code A but I do not think I can add any useful submission in relation to that.

Code A Dealing with Code A case the summary does indicate on the 28th December he was seen by Code A and then we go to the entry of the 30th December, but it does not specifically say that Code A made these prescriptions.

Code A You are absolutely right.

Code A I think also with Code A

Code A You are absolutely right. I hope I am deliberately minimising which I concede to be relevant and readable for your proper consideration. The reason why I thought it right to draw it to your attention was, one, she was obviously involved in the orothorm, I cannot say for certain whether or not she was involved in the driver. It may be that Code A can say and remember, it may well she cannot and we may need to look at the notes, but what one does know is this that she has certainly said before a constitution of this committee on earlier occasions that she was generally the only person there, yes there were others involved which is why I drew your attention to the notes in the first case. I would leave it as an entirely open question and whether it is right to draw an inference against her in relation to that diamorphine and the syringe driver you may think is not enough material to do so, but none the less right to draw it to your attention.

Code A The other case I had in mind was the Code A case where Code A arranged the admission but there is no specific mention in the summary as to who it was who prescribed the diazepam. It does not specify it.

Code A You are quite right about that . The next one was Code A at page 499. She went to the Dryad Ward, this is the top of page 500, where Code A Code A was pretty well in daily contact. On the 14th April 1988 the normal entry A happy for nursing staff to confirm death.@ Turning down to the 15th May 1998 summary seen by Code A re pain oramorph increased to 10mgs 4 hourly. 2lst May clinical notes further deterioration uncomfortable ad restless . Happy for nursing staff to confirm death. Summary - restless, agitated. Seen by Code A Syringe driver commended diamorphine 20mg at 09.40.. Then she deteriorated further. There is no further reference to Code A and I drew your attention earlier on in the summary in relation to Code A

Lastly Code A . He was admitted to the Daedulus Ward on the 26th April 1999,again one of Code A s two wards and on the 27th April he was seen by her that is shown in the fourth line, ASeen by Code A and family spoken to. Cyanosed and clammy. Wife thinks he will not survive. Dr said AI will make him comfortable.@@ In terms f his then state of health he had left hemiplegia secondary to CVA, angina, obese, hypertension, cardiac failure, non insulin dependent diabetic, prostatic hypertropy depression.
In terms of commentary by the expert, third paragraph

A A syringe driver.was set up with a high dose of diamorphine and midazolam. Code A Code A died forty five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Code A noted that he ay well have received less than normal since he had low blood pressure and was peripherally cyanosed.

The cause of death was shown as cerebral vascular accident and was certified by Code A Code A was cremated.

The large dose of diamorphine makes the care sub optimal but it had no effect on Code A Code A prognosis.@

That is the supplementary evidence.

My submission is that if you apply the test which I have propounded as to how you balance the public interest in doctors reputation, patient interest, both patient interest of the patients of Code A and the patient interest in having trust in doctors, with Code A Code A position that she is able subject to conditions still to practice as a general practitioner, it would be disproportionate for her to be suspended, but it would be proportionate and necessary that you should be satisfied that it is necessary that she be the subject of conditions either in the terms which I have suggested or in similar terms,otherwise than in an medical emergency she should neither issue nor write prescriptions or administer denzolbiate or opiates is of course limited to those where problems appear to have arisen. Look at the totality, look at all the circumstances of this case, it is clearly going to be a continuing enduring one for months still to come and you have three consultants who have criticised her in respects of which the condition is designed to deal with. You have a PCC reference, PPC has concluded in the past that there was a reasonable prospect that she would be found to be guilty of serious professional misconduct, you have police categorisation on expert advice that a number of cases in which she has been concerned are cases where there has been negligence in the sense of being beyond acceptable clinical practice and you have the scale of the police investigation. It is a different state of affairs from that which came before the first, second and third committee. Some of the evidence, much of it, has been before different committees and you must obviously bear that in mind to be fair. At the same time if the test that they have applied has been a conditional test I question whether or not it has been the right test. Those are my submissions.

Code A I will see if we have got any questions.

Code A It is really just a query on the documentation. I notice that the GMC=s notice of the hearing of Code A is dated 24th September which is at page537. It refers in the first paragraph to the Code A deciding on the referral. AAfter considering the information provided by the Hampshire Constabulary@ and then we have the report or summary from the Hampshire Constabulary which you have gone through in detail for us which was dated 30th September which is obviously after the date of this notice of the hearing. I wonder whether you have any comment on that?

Code A Clearly it was anticipated that there would be a statement forthcoming and that it was going to be forthcoming earlier than it was. We may have had anticipation of somewhat different from what came into the state in which it was produced. I do not know. One way or the other at the time that the letter of the 24th September was written the limit of what could be said was said in paragraph 3 and it gave the earliest possible notice of a hearing. There is nothing in the rules which says it has to be seven days. As a convention one goes for seven days. In truth we are exactly on seven days, it came in on the 30th September and was electronically forwarded on the same day. In effect it was early notice of the 7th October hearing with sufficient supporting material at that stage, about which reasonable concerns were expressed on behalf of Code A but there has been no application for an adjournment and we are here on both sides to go ahead today.

Code A There is no further information available to us which would indicate why the Code A made his decision?

Code A That is correct.

Code A We do not have any further questions. Code A ?

Code A I should begin by saying that I am very grateful to my learned friend for his thoroughness and for his even-handedness. Both of those things mean that I can be a lot briefer than I originally thought that I would have to be. I have to say a little bit about the background and could I begin by inviting you to look again at the letter which is at page 404 of the bundle MDU written on Code A behalf in August 2002. My learned friend has referred to this and I know you have read it before and I k now you will read it again but there are some matters which I wish to highlight. It is Code A position that she was forced because of the conditions in which she had to work to choose between optimal note keeping and proper patient care and notekeeping was a casualty, patient care was not. If you look at pages 404 and 405 you will see that she compressed her clinical sessions at the hospital into three and a half sessions each week. In the two wards over which she had responsibility there were a total of 48 beds for her patients care which were extremely high, and he points out in paragraphs 3 and 4 on page 405 which indicates that Code A Code A lacked effective Code A support and indeed during the time in which the formal allegations took place the second Code A was on leave, so already he inadequate Code A support if there was any was cut in half.

The penultimate paragraph on page 405 tells the story of Code A frantic life. She arrived at the hospital at 7-30 and she would visit both wards, reviewing patients and

liaising with staff before she commenced he general practitioner duties at 9 am. She visited the wards, she would do her general practitioner appointments between nine and lunch time and would often go back at lunch time to review patients and then after doing her afternoon session as a general practitioner she would frequently go back to the hospital about seven and stay there for sometime.

That is a picture of an extremely concerned and diligent doctor doing her best under horrific circumstances. Those circumstances were made clear by Code A to the management on a number of occasions APlease help, we need more funds, we need more staff@ but unfortunately those tries went unheeded. With the benefit of hindsight it might very well be the case that the wisest thing to have done would be to have resigned and of course Code A facing the problems that she has faced over the last few years regrets very much that she did not do that. That would have been the only way in which the management would have taken any notice, but unfortunately she did not want to let the patients down, she did not want to let down the nurses with whom she had a very close relationship and so she battled on. In battling on she did not make the notes that she should have made therefore it is not clear, it is accepted in relation to many patients, just what the clinical indication was for the prescription which is recorded.

This is a case of poor documentation, it is not case of poor patient care. My learned friend has taken you to the transcript of Code A evidence on page 413 and when you are making your deliberations today I would invite you to look at that again. There is some useful cross-referencing which deals with the position of the hospital which is to be found in the Commission about Health Improvement Report which was published in July 2002. I do not propose to burden you with what is a bulky document, there are quite enough pages in this case. There are a few passages I wish to highlight.

Code A Has Code A seen this?

Code A No, I do not imagine there will be huge surprises. Does Code A Code A want to see it?

Code A The answer is yes I want to, what I suggest when we have the break I suggest my learned friend goes ahead and if he could make it available to me during the lunch hour adjournment and anything I ought to say I will let you know, would that be a convenient way of dealing with it?

Code A Yes.

Code A There are three paragraphs I wish to refer. The first is paragraph 6. 8, this relates to the appraisal of supervision of clinical assistance. (Paragraph read) There the commission concluded that the work place was intolerable and the sessions that were allocated to Code A were inadequate to deal with the work she was required to do. The next paragraph is 7.9 (Paragraph read) Finally in this report there is a heading at 7.11 headed AOther trust lessons@. (Paragraph read)

That is a long boring list which indicates what had to be done in order to do properly the job which Code A was required to do. The conclusion I would invite you to draw from that is that Code A was operating in circumstances which made full notekeeping quite impossible.

The other important bit of background which has been referred to repeatedly this morning of course is that there have been three successive IOCs hearing which have not found any order is necessary. In the transcript at page 438 of the bundle, which relates to the IOC hearing on the 19th September 2002 there was a good deal of discussion between the Committee and the legal assessor and counsel about whether it was proper to make any order no new evidence having been adduced. It was decided there that no new order should be made because there was no significant new evidence. That in my submission is the proper way to deal with it in my submission. The question therefore arises what has changed since the last IOC hearing?
The important point which my friend makes is that the test which was applied on previous occasions is wrong and accordingly you have to reconsider all the material which was before previous Committees and apply the proper test, that was part of the reason for detailed consideration of all the previous evidence. He invited your attention to the case of Dr X and he invited you to adopt an alternative test which said if you are satisfied (a) in all the circumstances of this particular case that there may be impairment of Code A 's fitness to practice which poses a real risk to members of the public or may adversely affect the public interest or her interests and (b) on balancing her interests and the interests of the public an interim order is necessary to guard against the risk then the order should be made. I do not have a lot of dissent to that formulation save I suggest it should read if you are satisfied (a) in all the circumstances of this particular case a sufficiently robust case has been made that there may be impairment of Code A fitness to practice; that caveat is necessary to avoid a potentially ludicrous result. If one adopts that formulation then I would respectfully submit that for all intents and purposes the right test has been applied by previous committees. Both Code A formulation of the test and the test which I have formulated today begs the really important question which is the question begged by section 41A itself, how are you satisfied?
Code A test does not answer that question. It cannot be the case having regard to basic principles of fairness described if you like in terms of Article 6, that a malicious allegation by a patient of a serious offence can have the effect of causing the interim orders committee to apply a draconian order affecting a doctor in practice.

There must be implicit in the statutory requirement "to be satisfied" a basic requirement that you look for some evidence. What therefore amounts to satisfactory evidence, evidence sufficiently cogent for you to be satisfied? My learned friend says that the additional evidence which you have in this case is the fact of an ongoing police inquiry. That with respect does not add anything to the position which had obtained previously, the police inquiry had been going on for an awfully long time, yes it is right that we have now been told that the police inquiry will look at among other things the patients whose summarises are contained in the back of the IOC bundle. But we have known for a very long time that patients including these patients had previously been looked at, and there is not the slightest reason to suppose that those patients were not among the patients who were being looked at and in any event my learned friend I would say very fairly down played the weight which you should

attach to those summaries for all the reasons which he has identified; we do not know anything about their authorship, but without wanting to be flippant those summaries could have been compiled by a secretary with medical knowledge in the police department.

The neutral stance I would take is that it is simply more of what we have seen before. If we believe everything which is said in those summaries there is evidence of hurried and in some cases incomplete medical records. There is no indication there has been any inappropriate prescribing. There is sometimes inadequate documentation of the implication of prescribing but again I do not want to be flippant but it is important to understand the context in which this police investigation has happened. This has been an absolutely massive police investigation. When those instructing me spoke to the police in September 2003 my solicitors were told that a team of six detectives had been working full time on the case and as you have heard already that a number of experts have been called in, including experts from nursing, from forensic psychology, general practice, care and so on. I respectfully and rhetorically say that after all that expenditure, money time and manpower is that the best that there can be? They have been unable to put any firm allegations against Code A in the sense of new charges. In relation to the weight which my learned friend says he should attach to the fact that the preliminary proceedings committee have referred to the professional conduct committee, point 1 that is a matter which has already been considered by the committee and, two, a test in which the police are deciding whether to bring charges. We know what the police=s view of the present situation is because Code A has been very candid about it and a portion of his evidence has been read out ANo evidence of any criminal charges and we really do not know where we are going to go from here". Again I rhetorically ask should that be sufficient for you to say that there has been new material upon which you could be satisfied that the position has changed from previous IOC hearings and that statutory criteria in section 41A has been met?

Code A obviously thought that he had a very cogent point to bring before the committee, that was the issue of the undertaking about the opiates and benzodiazepines prescriptions; he thought as his statement makes clear that he had caught Code A out in breaching her undertaking. That quite plainly is not the case. You have seen the document in D1 Which is the formalised second undertaking which was given. You will see the terms where Code A prescribed diazepam where there was a clinical indication for doing so which was endorsed by the British National Formula. Code A has undertaken the exercise of looking at her prescribing over the period which is dealt with by Code A in his statement.A computer print out has been generated and if copies could be handed up. This is D2. My learned friend has seen this. It requires some explanation. It relates to diazepam prescriptions by other partners in the practice where Code A works during the material period. The names of the national health service numbers of the patients have been deleted so confidentiality is secure. You will see at the bottom of the first page Code A name and she is described there as the usual doctor, so all the entries under her name relate to prescritpions of diazepam which were given to patients for whom Code A was the usual doctor. That does not mean, as the medical people will know, that all the prescriptions were written out by Code A herself. The prescriptions which were written out by Code A herself are indicated on the right

hand side of the page by the initial Code A You will see four occasions on which Code A Code A has herself written out prescriptions for diazepam. The other prescriptions were written out by other doctors whose initials appear on the right hand side of the page on behalf of patients who were the usual patients of Code A In relation to each of the four prescriptions and Code A has gone back and checked all this and they were all for muscular type pain which is a legitimate prescription for that. That indicates Code A killer point before you, namely this is a doctor who breaks her undertakings and incontinently prescribes diazepam is a wrong point.

You are left solely with the question whether there is new evidence which justifies the departure from the IOC previous findings that there is need for an order in Code A Code A case.

There is no evidence at all that Code A is unable to prescribe safely in the GP context. That is the only context in which she now prescribes. There is every reason to suppose that all the concerns arose solely because of the pressures which arose in an appalling environment which a long time ago now she prescribed, it is a long time now since she was working on these wards and she has no intention of going back.

That being the case no proper public confidence issues arise. In her general practice she has an acceptable work load, the work load is divided between several partners and accordingly record keeping is simply not an issue either. Is it therefore necessary again for there to secure public safety that she has an order in the terms suggested by my learned friend? Absolutely not. The necessary protection was given by the undertakings which she has made and manifestly by this evidence has complied with. The Committee I know will be keen to guard against the tendency which arises in many high profile public cases of complying with what can amount to mob rule of a doctors inability to practice being interfered with simply because people make unsubstantiated allegations.
For all those reasons I suggest that there is no material on which you can properly conclude that the earlier committees were wrong in deciding that no order be made. Those are my submissions.

Code A I will just see if we have any questions.

Code A It is just to clarify a matter to do with the D2, the diazepam. Under the usual doctors, Code A list it is quite clear that other doctors whose names appear on this document have prescribed for her patients. Code A has prescribed morphine on a couple of occasion on Code A list and Code A has. What you have not indicated to us is how many of these prescriptions under the names of Code A Code A were actually written by Code A rather than by the doctors whose names appear at the top of the list. That is information that I think would be useful for the Committee to have if you are asking it to consider that this is an indication of the number of frequency that diazepam prescriptions are prescribed by Code A ?

Code A I can tell you, sir that none of the other prescriptions under other doctors names were written out by Code A

A

Code A Just on that point that Code A made. Perhaps when we look at the prescription under Code A under Code A it appears twice. Were there two prescriptions written by Code A

Code A I understand it was an error.

B

Code A It was an error, I think what it was when it was pressed down the computer generated two prescriptions.

Code A I just wanted to check when this report is dated.

Code A July 2002.

C

Code A We have in our bundle doctors arrested on suspicion of an offence and we have others who are formally charged and clearly we are aware of the police investigations which have been going on for some time. Has there ever been any stage where Code A has been arrested on suspicion?

Code A No, sir. She has been interviewed under caution in relation to the case of Code A and the police decided there would be no proceedings. The police interviewed her and the papers were sent to the Crown Prosecution Service and the answer came back that was the end of the case.

D

Code A So it was the CPS who decided in that case?

Code A Yes.

E

Code A At this stage we would normally ask the Code A for advice, but since Code A is going to look at this document at the lunch break it might be better if we break now and reconvene later.

Code A Could I just respond in relation to the legal matter and on the matter of a correction. The first is this my learned friend=s submission seeks to add some words to my test and he is trying to say effectively what does satisfy mean and the test he applied that it must be sufficient robust and goes on to say the basic requirement is that this committee must look at some evidence. This in my submission is obviously more important in this case essentially but I would suggest to you that that reason is wrong. The reason we can see it is wrong is Dr X. We know in Dr X there was no evidence, there was a charge, they did not look at the evidence underlying the charge, therefore in my submission the additional words which he implies do not add anything when he says what he means by it, they actually go further than they properly should.

F

G

In relation just to a correction he says we do not know anything about the authorship but in fact we know something. We know what Code A has said about it. In addition if one looks at page 507 we know one of the experts, Code A is expressly identified,therefore it cannot have been, to use my learned friend=s

H

forensic flourish simply a medical secretary. It may be a medical secretary who typed it but the substance of the matter cannot be limited to that.

In relation to other matters I would like to see the document and I will come back to you.

Code A I wonder if I can respond very briefly to that. I would accept that if a police investigation resulted in a charge then that charge is evidence within the ambit of the test proposed, but in the case of Code A we are a million miles from that; not only do we not have any charges, you have it indicated by the police on several occasions to take no action, so to suggest it is parallel with the case of Dr X where there were charges simply do not stand up.

Code A Right we will adjourn to 2pm

(Adjourned for a short time)

Code A I mentioned to my learned friend that I wanted to draw attention to one or two passages in this report. It is the only copy with have here. He has highlighted certain passages and when you retire you can look at the report. I could not hear clearly what Code A said but I understood it to be the case that the pressing down twice explained duplication of prescriptions in relation to the 15 items where they are duplicated. I think along side you will see some dates. While obviously that may well be the case, I am not questioning one way or the other, that in relation to the first entry, the third shown, nor the one April 9th, the one after that three from the end, the patient 1959 No 111496, you have got two different dates, one of which was the 7th November and the other 28th October and that would not marry with that explanation. The last is the penultimate one, that is dated 28th May but I merely draw that to your attention.
Can I respond to the report. The function of CHI which produces this report is not to investigate particular doctors and therefore the point my learned friend makes, there is no criticism of individual doctors, with respect is clearly limited, the absence of criticism is not a basis for the answer that none is to be found. This came into existence particularly to deal with systematic or systemic organisational problems in the provision of health care.Its remit is at paragraph 1.4 and I mention this in this context because you will find the passages to which I am going to draw your attention show that one would not generally expect to find individual criticisms and the terms of reference which were agreed on the 9th October 2001 are as follows.

AThe investigation will look at whether since 1998 there has been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within the services of older people inpatient and continuing and rehabilitative care at Gosport War Memorial Hospital. ...(reading to the words) .....care for older people.@

In the context of that remit none the less there are certain key conclusions and at page vii in the key conclusions I will alert you to this:

A

ACHI concludes that a number of ..... reading to .....were not identified.@

Those are amongst the key findings, the first one under Chapter 4, under the heading

AArrangements for the prescription administration and review@ ACHI have serious concerns ..... reading to ..... Would have been questioned.@

B

Then in relation to Chapter 5 under the heading of AQuality of care and patient experience.@
A Relatives speaking to CHI had some ..... ward now.@

Then in chapter 4 at paragraph 4.2, a chapter headed AArrangement for the prescription, administration and review of the calling of medicines, police enquiry and

C

expert witness reports@

A Police expert witnesses .....reading to ..... to reach the conclusions in this chapter.@

I have already given you the conclusions in the chapter at the beginning.

D

Then in relation to paragraph 4.4 on page 13 under the heading AMedicine usage@

A Experts commissioned by the police ..... number of patients treated.@

On the next page you have graphs.

E

Then paragraph 4.5

A The Trust=s own data ..... 2000 and 2001.@

Then there is the graph. Finally paragraph 7.9, my learned friend read the first sentence and could I read to the end

F

A Gosport Health Care NHS .....reading to ..... April 2001.@

Sir, are the paragraphs which I thought I would draw your attention to, there is nothing else I wish to say. Thank you very much.

Code A Could I just say this there is no new evidence which my friend read out which should alter your approach to this case. You may feel that the simple

G

question for this committee to decide is whether it is proper for the IOC committee to impose conditions on Code A 's fitness to practice on evidence primarily of a police officer's assertions that an enquiry is continuing without being able to give a coherent indication as to the nature of the enquiry or the evidence that the enquiry has. In my submission the answer to that question must be No.

Code A I will now ask our Code A for his advice?

H

Code A: This is an application under section 41A of the Medical Act 1983 for an interim order that conditions should be placed on the registration of Code A It is not suggested that her registration should be suspended.

I advise that the approach the Committee should now take is to consider all the particular circumstances of Code A case as they prevail today. This must include the circumstances as at the time of the three previous hearings when no order was made and to consider it in the light of the new material which is before them today.

I advise that before any order may be made the Committee must be satisfied that by reason of Code A intending to practice it is necessary for the protection of the public, or is otherwise in the public interest, for example, to maintain public confidence in the medical profession, or in the doctor=s own interest that conditions should be imposed on her registration. The Committee must consider proportionality. The protection of the public, particularly patients, and the maintenance of confidence in the medical profession, must be balanced against the consequences of an order for the doctor, such as interfering with her ability freely to practice her professional and the staining of her reputation.

Code A for the General Medical Council, has suggested a new test should be applied as to when the Committee should make an order. The advice which I have just given is in the same or similar terms to the advice which has always been given to this Committee since its inception with the omission of the words Aby cogent and credible prima evidence@ after Athe Committee must be satisfied@. With that omission my advice is in broad terms identical to Code A new formulation, although perhaps not so elegantly expressed.

Code A for the doctor, does not criticise Code A new formulation save he speaks to add Athat the committee must be satisfied that a sufficiently robust case has been madeMy advice is this: the Committee must act on the material which the General Medical Council and the defendant sees fit to call before it and that is a quotation from paragraph 18 of the case of Dr X to which reference has been made. This often includes material such as the mere fact of the doctor being charged or arrested for an offence or third party report. which would not possibly be evidence admissible in the criminal court or before the Professional Conduct Committee. That follows necessarily from the nature of the interim Order Committee function and the point in the proceedings at which that function is performed.

However, I advise the Committee that they are not required to act upon any material put before them. They must first consider its weight and quality; put another way, as was done by Code A at paragraph 25 of Dr X they should consider whether the material put before them in support of the application Aplainly and obviously lack substance.@ That may be no more than another way of saying AIs the material credible and cogent?@ If the Committee is satisfied that the material relied upon by the General Medical Council plainly and obviously lacked substance or is not credible and cogent they will not be satisfied that it is necessary to make an order.

That is my advice.

Code A Right if you could withdraw while we consider the matter.

(The Committee conferred in private)

Code A the Committee has carefully considered all the information before it today, including the statement dated 30th September 2004 made by Code A of the Hampshire Constabulary, the submissions made by Code A on behalf of the General Medical Council and the submissions made by Code A on your behalf.

The Committee has determined that it is not satisfied that it is necessary for the protection of members of the public, in the public interest or in your own interests to make an order in accordance with section 41A of the Medical Act 1983 as amended.

In reaching its decision the Committee has noted that the police investigation is at present ongoing and that you have noet as yet been arrested or charged with any offence. The Committee has taken into account the new material before it today, but it is of the opinion that this taken with the information before the IOC at previous hearings is insufficient to justify the imposition of an interim order. The statement provided by Hampshire Constabulary provides little substantive information and the Committee is unable to place sufficient weight on the supporting documentation.

The Committee has taken into account that no concerns have been revealed about your work in General Practice. The Committee has also noted that you have made a voluntary undertaking to Fareham and Gosport Primary Care Trust regarding the prescribing of opiates and benzodiazepines.

Notification of this decision will be served upon you in accordance with the Committee's Procedure Rules.

----oooOOooo----

Confidential
Addendum (I)
Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee
13 October 2004

Information: Further information:

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday 21 March 2002

Code A in the Chair

Case of
Code A

Code A was present and was represented by Code A of counsel, instructed by the Medical Defence Union.

Code A of counsel, instructed by Field Fisher Waterhouse, the Council's Solicitors, appeared in order to present the facts to the Committee.

Code A *introduced those present to* Code A *and her legal representatives.*]

Code A was previously before this Committee in June of last year, when she was subject to police investigation into the death of an elderly lady by the name of Code A at Gosport War Memorial Hospital in 1998. The only evidence before the Committee in June of last year were statements taken by police from her Code A, the medical notes of Code A and exculpatory statements by Code A herself, and by Code A the Code A geriatrician of the ward to which Code A was admitted. Those documents appear at pages 7 to 278 of the Committee's bundle. There was at that time no independent medical expert opinion indicating any fault on the part of Code A and, in those circumstances, the Committee found no grounds on which to make an order concerning her registration. The transcript of the proceedings is at pages 280 to 289 of the bundle.

As I say, at the time of that hearing the police investigation was still continuing, not only into the death of Code A but into the deaths of four other patients as well. The police subsequently received three experts' reports on these five cases: the report of Code A which is at pages 294 to 327 of the bundle, into the case of Code A only; the report of Code A which is at pages 328 to 334 of the bundle, which relates to the other four patients; and the report of Code A, at pages 335 to 373 of the bundle, which deals with all five cases.

Having received advice from counsel, the police decided not to prefer criminal charges against the doctor, but the reports were forwarded to the Fitness to Practise Directorate in the light of very serious concerns raised about the standard of care given by Code A and, in the light of those matters, it has been referred back to this Committee.

At the relevant time Code A was working as a Code A in elderly medicine at Gosport War Memorial Hospital. Can I deal with the reports, first of all insofar as they relate to Code A? Code A was a 91-year-old patient who was operated on for a fractured femur on 28 July 1998 and transferred to Daedalus ward at the hospital on 11 August 1998. She was further operated on on 14 August 1998 and returned to the ward on 17 August.

Code A's opinion is at pages 307 to 311 of the Committee's bundle. Perhaps I can summarise the opinions which I appear in those pages, I hope accurately. It says first of all that, despite recording that Code A was not in pain on 11 August 1998, she was prescribed wide dosage ranges of opiate and sedative drugs to which Code A was known to be sensitive. Secondly, when she returned to the ward on 17 August 1998 in pain, but not suffering any life-threatening condition, she was not given oral pain relief but continuous subcutaneous administration of diamorphine, haloperidol and midazolam from 19 August until her death on the Code A. During that time at no time did Code A appropriately review Code A condition. Also, thirdly, during this period there is no record of being given fluids as food in an appropriate manner.

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So far as Code A report is concerned, he deals with this case at pages 341 to 347 of the Committee's bundle. I would ask the Committee to refer to the paragraphs at 345-6, "Evaluation of drugs prescribed and the administration regimens". I shall not read out passages from those paragraphs but I shall, if I may, refer to the summary conclusions at page 347, in which the doctor says,

> "During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Code A These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death".

Perhaps I can move on to the second patient, Code A He was aged 79 when he was admitted to the hospital on 21 September 1998, to attempt to heal and control pain from a sacral ulcer. His case is dealt with by Code A and Code A s comments are at pages 330 to 331 of the bundle. Perhaps I can summarise his criticisms. He said, "Morphine was started without any attempts to control the pain with less potent drugs"; the use of a syringe driver was started without clear reason, and the dose of diamorphine increased without clear indication.

So far as Code A is concerned, his report into the case of Code A is at pages 348 to 354 of the bundle. Again, may I refer the Committee, without reading it, to the passage which is headed "Evaluation of drugs prescribed" at pages 350, and the summary at page 354, which I will read if I may.

> "The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Code A was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Code A I consider it highly likely that Code A experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression."

Moving on to the case of Code A she was an 81-year-old lady who was admitted to Gosport on 6 August 1998 with urinary tract infection, complaining of pain, and she was prescribed diamorphine. Code A deals with this patient at page 331 of the Committee's bundle and his comments are these:

> "There was no clear indication for an opioid analgesic to be prescribed and no simple analgesics were given, and there was no documented attempt to establish the nature of her pain. In my view the dose of diamorphine that was prescribed...initially was excessive and there is no evidence that the dose was reviewed prior to her death".

Code A deals with this at pages 355 to 358. His conclusion at 358 is this:

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> "In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death".

The case of Code A aged 75. He was admitted to Gosport on 14 October 1998, having suffered a fractured arm. He was also known to suffer with alcohol abuse, gastritis, hyperthyroidism and heart failure.

Code A deals with that at pages 331 to 332. He has no significant criticism of

Code A is more critical at pages 359 to 363. Again I would refer the Committee to the "Evaluation of drugs prescribed and the administration regimens", and perhaps I can read some extracts from those paragraphs.

> "The initial prescription and administration of oramorph to Code A following his transfer to Dryad ward was in my opinion inappropriate."

At paragraph 5.12,

> "The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate".

Paragraph 5.13,

> "The increase in diamorphine dose...is not appropriate...and potentially very hazardous. Similarly the addition of midazolam...was...highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive".

Finally, the case of Code A She was an 87-year-old lady who was admitted to Gosport on 27 February 1998 for palliative care, having been diagnosed with possible lung cancer. Code A deals with her case at pages 332 to 333 of the bundle. He says that, in the absence of any symptoms relevant to the cancer and of any pain, she was inappropriately started on opioid analgesia.

Code A deals with the matter at pages 364 to 368 of the Committee's bundle. Again, I ask the Committee to refer to his evaluation and to the summary at page 368. He says,

> "In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Code A on 3 March. In my view this was an inappropriate, potentially hazardous prescription".

That deals with the reports of those three experts.

The most recent developments in relation to the doctor's practice insofar as they relate to her hospital practice are revealed in letters from the NHS Trust, which are at pages 378 to 380 of the bundle. I would ask the Committee to have regard to those. They are both dated 13 February 2002.

It is clear that Code A has entered an arrangement with the Trust, and we can see at page 380 that it has been agreed that she "would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital" and that she "would voluntarily stop prescribing opiates and benzodiazepines with immediate effect". It would appear from page 378 that the arrangements that have been come to with her would be reviewed subsequent to this hearing.

So far as any conditions upon this doctor's registration are concerned, clearly the Committee will have regard to the issues of protection of the public and public confidence in the profession. It is our submission that it would not be appropriate that this doctor's registration should remain unrestricted, and that the voluntary arrangement into which she has entered should be formalised by conditions, perhaps along the lines of those imposed by the NHS Trust.

I know not whether the doctor has any private practice outside of her NHS practice, but it may be that the Committee would wish to consider imposing a condition which restricts her to NHS practice, for the purpose of her ongoing supervision. Those are my submissions on behalf of the Council.

Code A There may be questions from members of the panel.

Code A Is your last point that you certainly are not seeking for the Committee to consider suspending this doctor? I wanted to clarify that.

Code A It is a matter of course for the Committee, but I have taken instructions on it this morning to clarify the position. The position is as I have set it out.

Code A There is another matter, and it may be that Code A wants to develop this. I have no idea what is in his mind, but I wanted to seek clarification as to whether the Committee is entitled to know what is Code A's role in this matter, as is set out in the Hampshire Constabulary letter which is in front of us at page 292. There is implicit criticism there of the Code A in charge. Are we entitled to know whether that particular Code A has been referred to the Council, or whether the police are continuing their investigations into him, or whatever? It may be that could be relevant to the part that this doctor has played relative to the Code A

Code A I can certainly say that, so far as any police investigations are concerned, they are concluded, and there are no police investigations ongoing into Code A I wonder if I may take instructions on the other matter? [*Having taken instructions*] I have no instructions on any other action taken against Code A Code A

S14

Code A The working relationship between Code A and Code A might be explored through Code A.

In the absence of further questions, Code A would you like to begin?

Code A Sir, what I propose to do is ask Code A to give evidence before you.

Code A Sworn
Examined by Code A

Q Code A I want briefly to go through your *curriculum vitae*. The Committee will see from the front page of their blue papers that you qualified with the degree MB BCh 1970 in Oxford and that your home address is in Gosport. If we turn to page 266 of the bundle, we can see a statement produced by you to the police at a stage some months ago. I want to go through it with you, if we may.

You say in the second paragraph there that you joined your present GP practice, initially as an assistant, then as a partner and, in 1988, you took up the additional post of Code A in elderly medicine on a part-time session basis. You say the post originally covered three sites but, in due course, was centred at Gosport War Memorial Hospital. You retired from that position this year. I think you retired in the spring 2000, is that right?
A Yes, that is right.

Q How many sessions were you doing at the War Memorial Hospital? I think we have the answer at paragraph 4, but I will just ask you about it. Tell us how many sessions you were doing.
A The health care trust allocated me five Code A sessions, of which one and a half were given to my partners in the practice to cover the out-of-hours aspect of the job; so that I remained with three and a half Code A sessions in order to look after 48 long-stay geriatric beds. I would visit each of the wards at 7.30 each morning, getting to my surgery at nine. Towards the end of the time doing the job, I was back very nearly every lunchtime to admit patients or to write up charts or to see relatives. Quite often, especially if I was duty doctor and finished my surgery at about seven in the evening, I would go back to the hospital in order particularly to see relatives who were not available during the day because they were working. That became a very important time commitment in the job.

Dryad ward had no Code A cover for the 10 months that you are considering these cases. Code A was trying to cover both wards as well as her commitments on the acute side and the other hospital in the group, and found it very difficult to be there very often.

Q I will break it up and take it in stages, if I may. You would be there from 7.30 to nine o'clock each weekday morning, is that right?
A Yes.

Q You have mentioned two wards. One was Daedalus; the other was Dryad ward.
A Yes.

Q Were you in charge of both of the wards?
A Yes.

Q How many beds were there?
A Forty-eight in total.

Q Over the period with which this Committee is concerned, what was the level of occupancy typically of those 48 beds?
A We were running at about 80 per cent occupancy, but of course that was not enough for the health care trust towards the end of my time there. They attempted to increase it up to 90 per cent, which is running a unit very hot, when you have one part-time jobbing general practitioner and no increase in resources of nursing staff, support staff, OT and physio, and no support from social services.
Q How many other doctors would be there throughout the day to treat these 48 patients if all the beds were full?
A None.

Q So yours was the medical input?
A Mine was the medical input.

Q Between half-past seven in the morning and nine o'clock each weekday morning.
A Time to see each patient, to actually look at each patient, but not time to write anything very substantial about very many of them.

Q If you wanted to see relatives, were you able to see relatives at those early hours in the morning?
A No, except for that one particular case where they spent the night in her single room with her, with their notebooks. Generally, relatives preferred to see me either at lunchtime or in the evening. I would see them in the morning if it was that urgent, but it was generally not appropriate.

Q When you first started this job in 1988, what was the level of dependency typically of patients who were under your care?
A This was continuing care. This was people who – now, because their Bartell or dependency score is less than four, are a problem – went to long-stay beds and stayed there for the rest of their natural lives. So I had people that I looked after for five years, for 10 years, in these beds. The sort of people that I was given to look after in these beds generally were low dependency; they did not have major medical needs, but were just nearing the end of their lives. The analogy now, I suppose, would be a nursing home.

Q Did that position change as time went on?
A That position changed.
Q Tell us how.

5

A Continuing care as a concept disappeared. The National Health Service was no longer going to look after people who were as dependent as that. It was going to go into the private sector. I cannot give you an exact year, but it happened in the 1990s. At the same time, social services found that, with their budget constraints, they had difficulty placing people with a Bartell of less than four. So there was constant conflict between what we were supposed to be looking after and doing with the patients and what the private sector was going to take from us.

Q Just explain to us, what does a Bartell of less than four mean? What is the range of the Bartell scores?
A You or I have hopefully a Bartell of 20. That means we are able to take care of ourselves; do all the activities of daily living; cut up your food and eat it; go to the loo; change your clothes; walk about. Most of these people in the places mentioned have a Bartell of zero; I think one chap had one of four. So these were very dependent people.

Q That is an indication of the requirements made of nursing staff?
A Nursing requirements. They could not do anything for themselves, basically.

Q What you have told us is that, over time, the level of dependence of the patients increased.
A It escalated enormously: to the point where I began to be saying to my employers, "I can't manage this level of care for this number of patients on the commitment I have". But there was not anybody else to do it. During 1998, when the consultant on Dryad went on maternity leave, they made the decision not to employ a regular locum, so that I did not even have full consultant cover on that ward and so that Code A was left to attempt to help me with both, although she was not officially in charge.

Q Code A is...?
A Code A the other Code A

Q Did she have other clinical commitments outside the two wards with which we are concerned?
A She had her acute wards up on the Queen Alexandra site; she had a day hospital and outpatients to run down at the St Mary's site in Portsmouth – so she was a very busy lady.

Q How often was she able to undertake a ward round on the two wards with which you were concerned?
A She did not ward rounds on Dryad ward. She came to Daedalus on the Monday to do a continuing care round. Towards the end of my job she designated six of her beds as slow stream stroke rehab' beds, and she did a Thursday ward round – which I could not always make because it was my antenatal day. She was in the hospital and doing outpatients on Thursday as well, so she was in my hospital twice a week – but available on the end of a phone if I had a problem.

Q You have told us that over a 10-month period there was no Code A cover at all.
A Yes.

Q That is 10 months during 1998, which is the period essentially within which the cases that this Committee have been asked to consider fall?
A Yes.

Q Were your partners in your GP practice able to help at all?
A My partners provided the out-of-hours cover – those who were not using Healthcall. They would admit patients who arrived from the district general hospital and see that they had arrived safely. They were in general unwilling to write up pro-active opiate prescribing or any prescribing for patients because they felt that I was the expert and it should be left to me to do it. I think they felt it was not part of their remit, providing cover for me, to prescribe for the patients.

Q So if anyone was to prescribe opiates or other forms of strong analgesic to patients, would it always be you?
A It was generally me.

Q We know that your time at the War Memorial Hospital was limited to the mornings, lunch times and evenings, when you told us you would see relatives. If you were not in a position to prescribe for the patient and the patient was experiencing pain, what provision was there for another doctor to write up a prescription?
A They would have to either ask the duty doctor to come in or they would have to ask the duty Healthcall doctor to come in. That is why, in one of the cases, you see somebody has written up "For major tranquillisers" on one occasion, because that duty doctor obviously either felt it inappropriate or was unwilling to use an opiate and he wrote up major tranquillisers instead.

The other alternative was, of course, that they would ring me at home. If I was at home – and I am only at the end of the road in the village – I would go in and write something up for them, outside the contracted hours.

Q You have said that your partners regarded you as the knowledgeable one about opiates and palliative care.
A Yes.

Q Tell us what your experience may be in those areas.
A In 1998 I was asked to contribute to a document called the *Wessex Palliative Care Guide*, which was an enormous document that covered the management of all major types of cancer and also went into management of palliative care and grief and bereavement. Each month, another chapter would arrive through the post for you to make comments on, contribute your experience to and send it back. This document was published in 1998 as the *Wessex Palliative Care Guide* and we all carry the *Wessex Palliative Care Handbook* around with us, which contains a sort of—

Q Is <u>that</u> it?

A Which you carry in your coat pocket. [*indicates document*]

Q You contributed towards that?
A I contributed to the writing of that and I am acknowledged in the thanks in the major document. I attended postgraduate education sessions at the Countess Mountbatten and also at the other hospice locally, The Rowans.

Q Just remind us, where is the Countess Mountbatten?
A The Countess Mountbatten is part of Southampton University Hospitals and it is in Hedge End, which is about 10 miles from Gosport. The Rowans is a similar distance in the other direction. I am still in very close contact professionally with both the director and the deputy director of Countess Mountbatten. I still go to their postgraduate sessions and I still talk to them about palliative care problems. They are always very available and helpful, and of course they provide district nursing, home care nursing input into our community, which is enormously helpful in general practice.

Q Are you – perhaps I can use the expression – up to date in developments locally in primary care and matters of that nature?
A I was also, at the time of these allegations, Code A of the local primary care group which, on 1 April this year, becomes a primary care trust, so that I was very involved in the political development of our district. I knew only too well that the health care trust could not afford to put any more medical input than I was giving them, on the cheap as a Code A, into our cottage hospital at that time. I knew what the stresses and strains were on the economy and I knew where the money needed to go.

I could have said to them, "I can't do this job any more. It's too difficult; it's becoming dangerous", but I felt that I was letting them down. I felt that I was letting down the nursing staff that I had worked with for 12 years, and I felt that I was letting patients down, a lot of whom were in my practice and part of my own community. So I hung onto the job until 2000. In the thank-you letter I got for my resignation letter they said that I "would consider, wouldn't I, the three quarters of a million they were looking for, to beef up community rehabilitation services in the district" – which included replacing my job with a full-time staff grade, nine-to-five, every weekday in Gosport.

Q We will come to some correspondence shortly. After you resigned, your job was taken over by another doctor?
A Yes, a single, full-time staff grade. I hear on the grapevine that the bid has gone in for two full-time staff grades to do that job now.

Q Is this to do the job that you were doing within three and a half Code A Code A sessions?
A In three and a half Code A sessions. It is just a measure of the difference in the complexity and the workload that is being put into a cottage hospital.

Q Can I ask about your note-keeping? You had a significant number of patients; it was at 90 per cent occupancy. Clearly that is—

A Between 40 and 42 patients, yes.

Q What time would you have during your clinical session to make notes for each of the patients?
A You could either sit at the desk and write notes for each patient, or you could see the patients. You had that choice. I chose to see the patients, so my note-keeping was sparse.

Q You accept, I think, as a criticism that note-keeping should be full and detailed?
A I accept that, in an ideal world, it would be wonderful to write full and clear notes on every visit you pay to every patient every weekday morning.

Q But the constraints upon you were such, I think, that you were not able to do so?
A Yes.

Q Were the health authority aware of your concerns as to staffing levels and medical input?
A Yes.

Q Were they aware of your concerns over the increasing level of dependency that patients had who were transferred to your unit?
A Yes. In the dreadful winter of 1998, when the acute hospital admissions – admissions for acute surgery and even booked surgery – ground to a halt because all their beds were full of overflow medical and geriatric patients, my unit received a letter asking us to improve the throughput of patients that we had in the War Memorial Hospital, accompanied by a protocol for the sort of patients we should be looking after: how they should be medically stable and everything like that. I wrote back to the then Code A and said, "I can't do any more. I can't really even look after the ones that I have got, because of their dependency and medical needs. Please don't give me any more". I got a bland reply, saying that we were all going to try to help out with this crisis in the acute sector.

Q We will look at the correspondence. Can I come to nursing staff, your relations with them, and the experience of the nursing staff? Clearly you started 12 years before you retired. Did the number of nurses increase over the period of time that we are talking about?
A Marginally.

Q What about the level of experience of the nursing staff? The impression that we have is, towards the end of the period, you are dealing with patients who had very high dependency. Was the experience of the nursing staff raised in order to meet that increase in need?
A By an large they were the same people and they learned in the same way that I did: by having to deal with these more difficult needs. I do not think I can comment on how much input the Trust put into improving their skills. I think that would be inappropriate for me to do.

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Q Perhaps I can ask this. Was it apparent that the Trust were seeking to raise the level of experience and qualification of the nursing staff in the War Memorial Hospital? And the answer should go on the transcript.
A Does it?

Q Was it apparent?
A It was not apparent that they were making any great attempts to improve the cover, the experience and the training of some of the nurses.

Q Were the health authority aware of your concerns, both as regards nursing levels and levels of medical staff?
A Yes. I did not put anything in writing until 1998 – or was it 2000?

Q I think it was 2000.
A 2000 -- but I was in constant contact with the lower echelons of management. Any remarks you made about the difficulties you were having, the worries you had and the risk of the patients you were covering, would definitely fall on stony ground.

Q You chose to prescribe opiates. It is something which is criticised by the experts whose reports are before the Committee. You chose to prescribe over a range, and quite a wide range, for certain of the opiates that we have seen.
A A professor of geriatrics in a teaching hospital, or even a big district general hospital, will have a plethora of junior staff. There will be never any need for any opiate dose to be written up for more than 24 hours, because somebody will either be on the end of the bleep or be back on the ward. That was not the case in Gosport War Memorial. If there was a weekend, if I was on a course, if I was on sick leave, if I was on holiday, I have already explained that there was not the cover for someone else to write drugs for me, and therefore I wrote a range of doses. I implicitly trusted my nursing staff never to use any of those doses inappropriately or recklessly. You will see from each of the documents that there is no question that any of these people received enormous amounts of opiate or benzodiazepine.

Q If the nurses wished to move from one level of administration of opiate up tot he next stage, but within the range that you had already prescribed---
A They would speak to me.

Q How would that happen?
A Because I was in, if it was a weekday morning. I was on the end of the phone in surgery or, if I was at home and it was a weekend and they were worried, they would ring me at home. I did not have any objection to that.

Q Did you feel that your relationship with the nursing staff was such that such informal communication could take place?
A I trusted them implicitly. I had to.
Q What we see again and again in the comments of Code A and others is that the expert can see no justification for raising the level of prescribing. The expert in each case will have looked at the notes. Was there always

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recorded a justification for increasing the level of prescribing or the level of administration?
A Not always in my notes. I would hope that the nursing notes would be copious enough. In particular, interestingly, the night staff tend to make more of a full record of what the patient has been like through the night. It was quite often their feeling, night sister's feeling, that the patient was less comfortable or was beginning to bubble, or something like that, that would suggest to me that we needed to move up a step or in a step with the drugs we were using.

Q I will ask you to turn to page 370, which is the final couple of paragraphs of Code A s report. Paragraph 7.5, two-thirds of the way down that paragraph, he says,

> "It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward".

What do you say about levels of nursing staff on the ward during the period with which we are concerned?
A He is absolutely right. These experienced, caring nurses had the choice between tending to patients, keeping them clean, feeding them and attending to their medical needs, or writing copious notes. They were in the same bind that I was in, only even more so. As you can see from the medical records you have had, the health care trust produces enormous numbers of forms, protocols and guidelines, and sister could spend her whole morning filling those out for each patient or she could nurse a patient.

Q He goes on,

> "Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards".

Do you have a comment on that?
A I agree entirely. There was inadequate senior medical input.

Q During 10 months of 1998 was there any senior medical staff input?
A No.

Q It is not apparent that Code A was aware that you were doing three and a half sessions—
A In a cottage hospital.

Q ...in the cottage hospital.
A No.
Q It may be that Code A believed that you were permanent staff.
A Failed junior staff! His last comment in paragraph 7.5 – his review of Code A s medical notes – is absolutely correct. She was caring and thoughtful and considerate, and with a considerable workload – probably more than she

should have been carrying. Therefore it is difficult to criticise. She did what she could, within the constraints that she had available to her.

Q I am not going to go through the individual cases. This is not a trial; this Committee is not here to find facts proved or not proved. But I think it fair to you to invite you to comment on Code A s next paragraph. He says,

> "...the level of skills of nursing and non-consultant medical staff" – it was only you – "and particularly Code A",

– the word "particularly" suggests he may have believed there were other medical staff –

> "were not adequate at the time these patients were admitted".

How do you respond to that?
A I find it very upsetting. I was only a Code A The definition of a clinical assistant is in fact that it is a training post, and the only training that I received was that I went to get for myself as a part of my postgraduate learning, and I did my best at that time. In my opinion they were probably adequate.

Q Can we turn to the last page of the bundle, page 380? This is a letter dated 13 February 2002 and sets out matters that were agreed between you and the Code A Yes?
A Yes.

Q Attention has already been drawn to this document, but is it right that you agreed to cease to provide medical care, both in and out of hours for adult patients at the Gosport War Memorial Hospital?
A Yes.

Q And you agreed voluntarily to stop prescribing opiates and benzodiazepines.
A I did.

Q Had you not agreed those, were you threatened with any action?
A Code A told me that, under the change in Government legislation on 14 December last year, he was entitled to suspend me from general practice; but he did not wish to do that and, provided we came to this voluntary agreement, he would wait to see what the GMC had to say on the matter.

Q This is the same health authority who had been putting through a significantly higher volume of patients to your cottage hospital and with much higher levels of dependency?
A This is the employers of the health care trust who had been putting through significant.... The health authority in fact purchase work from the health care trust and, theoretically, employ general practitioners. So this was my employer telling me that he could suspend me from the day job as well. So I agreed to the voluntary restrictions on my practice. At that time I had four patients in general practice on opiates and approximately 15 on any form of

benzodiazepine. I handed the four patients over to my partners and said I felt no longer able to treat them. I no longer sign any prescriptions for sleeping tablets in general practice; the other partners do that for me.

Q You have given us the figures. Do you describe yourself as a high prescriber of benzodiazepines?
A I was quite surprised at how few of my patients got benzodiazepines from me.

Q And of those prescribed opiates----
A One was for terminal care. She went into hospital a couple of days after I was suspended and died there. The other three are maintained by the partners for longstanding chronic pain.

Q Just to remind the Committee, in your statement at page 266 you say in paragraph 3,

> "As a general practitioner, I have a full-time position; I have approximately 1,500 patients on my list".

A Yes.

Q *The Committee can see, of the 1,500 patients, precisely how many are* prescribed benzodiazepines and/or opiates.
A Yes.

Q [*To the Committee*] Sir, we have a small bundle of correspondence. I am sorry that you have not been given it in advance.

Code A We will refer to it as D1. [*Same handed*]

Code A Sir, we are giving you a number of letters. I am happy if they are collected in D1, or we can number them sequentially.

Code A I assume they have been circulated. Shall we put them in chronological order?

Code A I would be happy with that. The first letter you should have is one dated 16 February. It is from the Code A He talks of a "bed crisis at Queen Alexandra Hospital continues unabated". "It has fallen on us", he says,

> "to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some under-utilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post-acute patients. A policy offering guidance is enclosed".

You should see a document, enclosure 2, "Emergency use of community hospital beds". You will see it reads,

"Due to current crisis with the acute medical beds at Queen Alexandra Hospital and the detrimental effect on surgical waiting lists, the Department of Medicine for Elderly People is making some urgent changes to the management of beds in the small hospitals".

Can I break off and remind the Committee, this relates to the year 2000. The situation with which you are concerned for the five patients whose records you have were treated in 1998. So this is after, but we hand these documents to you to give you the continuing picture. You will see,

"Therefore patients referred to these beds for post-acute care should be:

1. Waiting for placement...
2. Medically stable with no need for regular medical monitoring...",

and the other matters that you see listed.

The next document is a letter from Code A dated 22 February to Code A The letter reads,

"I was very disappointed and also quite concerned to be shown a letter from yourself dated 16 February on the subject of the bed crisis at Queen Alexandra and addressed to the various ward managers and sisters.

Less than a month after I wrote a letter to the clinical director expressing my concerns about the situation in our continuing care unit, I find that we are being asked to take on an even higher risk category of patient.

These post-acute patients have a right to expect a certain standard of medical care, appropriate levels of therapy and supervision, and appropriate out-of-hours cover during this period of time in hospital.

I find myself without a Code A or seamless locum Code A cover for a period of a further month on one of the wards, and the other Code A cannot be expected to provide anything other than firefighting support during this time.

As a result, I am unable to do the Code A job to a safe and acceptable standard, which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition, my staff are subjected to ever-increasing pressures from patients and relatives, causing stress and sickness levels to rise.

I would also question the term 'under-utilisation' in a unit which is handling approximately 40 per cent of the continuing care done by Elderly Services at this time".

The next document in time is a letter from Code A dated 7 March, by way of response. I do not need to read it to you, but you have heard Dr Barton suggest

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that there was a request, effectively, for three quarters of a million pounds from the primary care group to go towards the local hospital. You may find a hint of that in the last paragraph of this letter.

The next document is the one with the fax strips down the centre of it. It is a letter from Code A dated 28 April 2000, tendering her resignation. It is addressed to Code A and it reads as follows:

> "Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport War Memorial Hospital. I have highlighted these worries on two occasions previously in the enclosed letters.
>
> I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example, on one of the wards I will only be having locum Code A cover until September. In addition, an increasing number of higher risk 'step down' patients continue to be transferred to the wards, where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.
>
> The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation".

You will see a reference to the original contract of employment in 1993.

The last letter, dated 19 May from Code A is one responding to the letter we have just read. The second paragraph reads as follows:

> "I am writing to offer my thanks for your commitment and support to Gosport War Memorial Hospital over the last seven years. There is little doubt that over this period both the client group and workload have changed and I fully acknowledge your contribution to the service whilst working under considerable pressure".

Sir, that is the evidence I seek to place before you. I have called Code A and, if there are questions for her, the Committee or Code A may wish to ask those questions now before I go on to sum up, if I can put it that way.

Code A, do you wish to ask questions?

Code A I have no questions, sir.

Questioned by the COMMITTEE

Code A Did you have Code A cover during 1998?

A I had a lady called Code A who became pregnant, who commenced her annual leave on 27 April 1998 and followed on with Code A Code A from 1 June until 8 February 1999. So basically she was Code A and then she was gone for the rest of the year.

Q And no replacement or locum cover?
A No.

Q So you were in fact on your own in a training grade post?
A Yes.

Code A I would like to ask some questions in order to have a feel for the 48 beds you were looking after with regard to patients. You mentioned the Bartell Score, that I am not familiar with at all but I am pleased that I am at 20.
A On a good day!

Q Absolutely! You said that the bed occupancy rate was about 80 per cent when you were there. Perhaps you were looking after about 38, up to 40 patients?
A Yes.

Q With regard to your looking after those patients, could you give us a feel of what you did? You said you were there for an hour and a half in the morning. Can you run through fairly quickly the typical kind of week you would have at the hospital?
A I would arrive as they opened the front door of the hospital at 7.30 and I would go straight to Dryad ward first. I would walk round the ward with the nurse who had just taken the night report, so it was the most senior nurse on. We did not, fortunately, have these named nurses at that point. I would stop by every bed and I would ask, "Are they in pain? Have they had their bowels open? Do I need to see the family? Is there anything I should know?". So I got a report at the foot of each bed. That was Dryad.

Daedalus liked to do it slightly differently, in that I did the report with the person who had taken the hand-over in the office, and then was invited to look at any patients they had concerns about. They preferred to do it in front of their paperwork. But the concept was the same: you went through all the patients in your care each morning, and that took until just before nine.

Q How many days a week did you do that?
A That was five. That was each weekday morning.

Q Was that your total involvement with the hospital?
A That is when it started. Generally, with the rate at which we were running admissions in 1998, I think an average week would contain five admissions. I had to try to get them to bring them down to my hospital before four o'clock in the afternoon. Lunchtime was better, because (a) they get very cold and stressed if you carry them round the countryside and bring them in after dark and (b) it gave me time to clerk them and to check whether any further investigations, bloods or anything needed doing, and to get them settled into the ward. So I would go back most lunch times, unless I had a PCG or purchasing meeting or something like that. In those days I was only on duty once a fortnight, but I would quite often go back in the evening if I felt there was somebody I was particularly worried about – to talk tot he relative or to support the nursing staff.

Q Code A put in front of us a number of documents, including the second one, which is "Emergency use of community hospital beds". In point 7 there, the second sentence reads, "...this placement does not entitle patient to NHS continuing care".
A There was no such thing in 2000. If your condition became medically stable and you could persuade social services to either fund you or agree to have you at all, then you would be moved on – even though your dependency score might be very low.

Q In that period, say 1998 to 2000, were you experiencing dilemmas whereby – and I use the word "conspiracy" advisedly, because I have the evidence from a report that I chaired during that period when I was in another post in the House of Commons – in evidence we had it said that there was a conspiracy between social services, doctors and management with regard to trying to push people who were entitled to have NHS care out of hospitals into nursing homes, where they would have to pay out of their own resources? Were you in that horrible dilemma?
A If you knew anything about Gosport, you would realise that (a) there is not much potential for private practice and (b) there were not vast numbers of patients who were self-funding. Self-funders were not the problem then. If they were stable and social services would agree that they could go to a nursing home at all, that was not the problem. I would never conspire with anyone in social services.

Q I was not levelling that at you. I was just thinking about the dilemma, that if you had patients in beds, such as the patients you were dealing with, then they would be covered in terms of the NHS system—
A They were not.

Q They were not?
A They were not. They were not entitled to stay in any of those beds. In order to keep them in those beds, you had to write in the notes, "Requires ongoing medical care". Despite a Bartell of zero, if they required no further medical input and their medical condition was stable, you then had to find them a nursing home. But the sort of people we are talking about here were not going to become stable.

Code A You refer to raising concerns in 1998 verbally with lower levels of management about your working situation. Would you be prepared to say a little more about what you actually did and whether you considered putting your concerns in writing at that point?
A I should have put my concerns in writing, because I was sitting on these strategic bodies. We were talking about how the health community was going to move forward, how we were going to improve step-down care, and how we were going to make available more beds for acute surgery so that the Trust achieved its waiting list targets and therefore its money from region. But I did not put anything in writing. I became increasingly concerned. I spoke to lower management, who probably did not even relay those concerns further up. I spoke to my clinical colleagues.

Code A tried at that time to get more funding and was unsuccessful. The first time we got any extra funding was in 2000 when I resigned and we got an extra three-quarters of a million for St Christopher's and Gosport War Memorial to do more post-acute rehabilitation work. So they knew we were in trouble, but I did not go to print at that stage.

Q Could you say approximately how many times you raised these matters with people in lower management?
A Once every couple of months.

Code A I wonder if I might be allowed to ask a few questions, just so that I understand the situation? Am I correct in assuming that Gosport War Memorial Hospital is a stand-alone community hospital?
A It has no theatre facilities; it now has no A&E or minor injuries facility; it has a little X-ray department with basic, standard equipment in a Portacabin. It has a little outpatient department to which consultants come down from the centre to do peripheral clinics, and it has approximately 100 beds.

Q These are including the 48 long-term care beds?
A We have long-stay elderly medical patients; we have babies; we have a maternity unit and we have a small GP ward.

Q Can you tell me roughly what the average length of stay was in, say, 1989, about 10 years ago, and then in the later part of the 1990s? How had the average length of stay changed?
A I had patients I had had for five years. I had some very ill patients transferred from the Royal Hospital, Haslar, after orthopaedic surgery or transferred from the main unit because they lived in Gosport and their relatives lived in Gosport. But those were the minority. The majority of patients were long stay.

Q Was there a calculation of the average length of stay in the early 1990s?
A It would be difficult to do, because we also did shared care and respite care in those days. I was looking at the figures the other day. You would find it very difficult to get a feel for the average length of stay, but it was generally reckoned to be a good long time. Then in the late 1990s – I could not find any research on this subject, but there are two major risk times for these elderly transferred from a nursing home to an acute unit and then down to a long-stay unit. They may well die in the first two, three days – something to do with the shock of being moved really makes them quite poorly. If they survive that---

Q While you do not have a specific figure for average length of stay, you are quite convinced that the dependency level increased over the decade?
A Massively, yes.

Q We are aware of how the Code A case came to the surface. It is not clear to me from the papers how the other cases were identified. Can you help me with that? [Code A *conferred with counsel*]

Code A Sir, you will recall from what I said to an earlier constitution of this Committee that the relatives of Code A complained. What I said to an earlier Committee was that they complained about everybody, including the police officers who conducted the inquiry. They generated some publicity locally about their concerns, as a result of which relatives of other patients – and I think the four with which you are concerned – expressed concerns. I think that is how the police became involved in those other cases.

Code A The health care trust also decided to invoke CHI, the Commission for Health Improvement, and CHI produced a lot of local publicity saying, "If you have any concerns about your hospital, this is the phone number, these are the people to get in touch with". And of course I have no input as to how much and where they got their information from; but they must have received an enormous amount of positive and negative feedback from the people of Gosport.

Code A Technically, as a Code A you did not carry ultimate responsibility for the clinical care of patients?
A No. You will see in a couple of the reports that we were using the Fentanyl skin patch for opiate pain relief. I was not allowed to sign for that. That had to be countersigned by a consultant. I was working for a consultant.

Q And the consultants under whom you worked reviewed the prescribing practices that you indulged in, did they?
A I do not know. Not with me.

Q So you did not do the ward rounds with the consultant?
A Yes.

Q You did?
A Yes, but no comments were made at any time at this point about reckless prescribing or inappropriate prescribing.

Q They did not raise any questions about the prescribing that was being done for these patients?
A They did not raise any concerns, no.

Q Were there any audit meetings in the hospital?
A I did not go. I was not invited to go to audit meetings.
Q Turning to page 380, I would also like some clarification. It implies in the first bullet point there that there is still some relationship to the Gosport War Memorial Hospital. What was the continuing relationship you had?
A In Gosport there is something called the Gosport Medical Committee, which is made up of all the practising doctors on the peninsula, which I think at the moment is about 36. We are employed by the health care trust to look after 20 GP beds upstairs from my erstwhile geriatric beds. We have admitting rights to those beds and we are allowed to look after our own patients. We are also invited to look after step-down patients from the acute unit. Although, as a GP you can be much more hard-nosed about refusing to accept somebody who you feel is beyond the capability of the hospital to look after than I could as a Code A Code A downstairs in the wards. That is why you will see something about, "a

retrospective audit of your prescribing on the Sultan ward". That is, what I was doing – whether I was prescribing inappropriate opiates upstairs on the GP ward.

Q That has been helpful clarification. Was I correct in assuming – this is the second bullet point – that you told us this was in relation to your primary care duties?
A The voluntary stopping prescribing opiates?

Q Yes.
A Yes, I am not prescribing any opiates or benzodiazepines at the moment.

Code A I think these are the points I wanted to raise. Are there any further points from members of the panel? In the absence of further points, Code A ?

Code A There is one, sir, and it was raised by Code A. Do you have any private patients?
A No.

Code A Sir, may I sum up very briefly? You may think that this is plainly an excellent and dedicated doctor. It may appear to you, and I would encourage this view on your behalf, that it may have been problems with the allocation of resources at the Gosport War Memorial Hospital which has led to a situation where best practice was not followed.

You will have to consider the reports of the various experts placed before you. You will have to consider as well whether they are considering Code A s position as it was. I may have missed it, but it is not apparent from my reading of the reports that there is shown to be an understanding by Code A and the other doctors that they were well aware that Code A was working three and a half sessions; that she was effectively, during the period with which we are concerned, the only medical input into the care of these patients; that she had a significant number of patients to see and to evaluate and to continue to care for, in a very restricted period of time.

You have to consider whether it is necessary for the protection of members of the public to impose conditions. I do not deal with the question of suspension because I say that it is plainly not appropriate in this case.

Is it necessary for the protection of members of the public to impose conditions? Code A is no longer undertaking the job that she started in 1988. You know the reasons why. I say she poses absolutely no threat to members of the public, either in her general practice or in any form of hospital medicine. She does not undertake any of the latter.

Is it necessary in her own interests to impose conditions? I say not. The last issue is whether it is otherwise in the public interest. You will know that there has been a police investigation, in fact two, arising out of the complaints in this case. You will know the results of the police investigation: that a decision has been taken not to charge.

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I repeat what I have said. It is slightly troubling that it is not apparent that the experts instructed by the police have been presented with the full picture of Code A 's clinical involvement with these patients before being invited to express a view. But I say that it is not in the public interest either for this body to impose conditions upon this doctor in the circumstances in which you know she practises. She does not pose a risk to patients. It is not necessary in her interests, and it is not otherwise in the public interest.

If, however, you feel that because of police investigation, because of the possibility of press coverage, that it is necessary to demonstrate that this body is able to make decisions, I would invite you to do no more than reimpose what Code A Code A has voluntarily agreed with the health authority.

Those are the submissions that I make.

Code A I now turn to the Code A

Code A The advice I give the Committee is as follows. They may make an order restricting this doctor's registration only if they are satisfied it is necessary to do so for the protection of members of the public, otherwise in the public interest, or in the interests of the doctor. In addition they must be satisfied that the consequences of any restriction that they might impose of her registration will not be disproportionate to the risks posed by the doctor remaining in unrestricted practice.

Code A unless there is anything else on which you would like me to advise the Committee, that is the advice I give.

Code A Sir, I have mentioned the little green book with which Code A has helped. I leave it with you.

Code A Thank you.

The parties withdrew by direction from the Chair and the Committee deliberated in camera.

The parties having been readmitted:

Code A the Committee has carefully considered all the evidence before it, including the submissions made on your behalf.

The Committee has determined, on the basis of the information available to it today, that it is not satisfied that it is necessary for the protection of members of the public, in the public interest or in your own interests that an interim order

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under Section 41A of the Medical Act 1983 as amended should be made in relation to your registration.

HAMPSHIRE CONSTABULARY

Code A

Code A

Date of Birth: Code A Age: **92**
Date of admission to GWMH: **14th April 1998**
Date and time of Death: Code A
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: Code A **days**

Code A 's past medical history:-

1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

Code A lived at Code A Residential Home. She had a Code A and Code A It was noted that she had poor mobility and was confused at times. Code A sustained a fractured neck of femur at Code A on 2nd April 1998 and was admitted to Haslar Hospital for surgery to correct the fracture. She was then admitted to Gosport War Memorial Hospital on 14th April 1998 for continuing care.

On admission a Waterlow score of 30 was recorded with another score of 29 recorded on 8th May 1998
A nutritional assessment plan was completed on 15th April 1998 with a score of 4.
Barthel ADL index was recorded on 14th April 1998 scoring 0, another on 25th April 1998 scoring 1 and another one on 9th May 1998 scoring 4
A handling profile was completed on 16th April 1998 noting that Mrs Lee needed the assistance of 2 and a hoist for transfers.
A mouth assessment was completed on 15th April 1998.
Care plans commenced on 14th April 1998 for MRSA screening, 15th April 1998 for sleep, 16th April 1998 for hygiene, nutrition, constipation and on 26th April 1998 for small laceration right elbow.

HAMPSHIRE CONSTABULARY

14th April 1998

Clinical notes – transferred to Dryad Ward from Haslar for continuing care. Barthel 0. Make comfortable, **happy for nursing staff to confirm death.** It was noted that Code A has sustained a right fracture neck of femur and had undergone surgery of canulating screws on 3rd April 1998. It noted that Code A Code A had poor mobiltiy needed the assistance of 2 nurses, was confused at times, needed full assistance with eating and drinkng due to poor eye sight and that she had a poor appetite. She needed all care for hygiene and dressing and her pressure area were intact and that she needed nursing on a pressure relieving mattress.

Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

Summary – restless, confused. Oramorph 5mg 4 hourly.

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

Clinical notes – MRSA negative. Bottom slightly sore. Start gentle mobilisation will not be suitable for Addenbrookes. Seen by Code A has severe dementia.

24th April 1998

Summary – fell while attempting to get up from commode. Sustained skin flat to right elbow. Accident form completed. Code A informed.

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge.

Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

Summary – seen by Code A re pain oramorph increased to 10mgs 4 hourly (20 mgs nocte).

18th May 1998

Clinical notes – increasingly uncomfortable when I called much better on oramorph.

20th May 1998

Summary – visited Code A For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**

Summary – restless, agitated. Seen by Code A Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

22nd May 1998

Summary – grimacing when turned. Syringe driver renewed at 09.30 diamorphine 20mgs and midazolam 40mgs. Continues to mark, position changed every couple of hours.

23rd May 1998

Summary – syringe driver recharged at 7.35. 20mgs diamorphine 40mgs midazolam. Position changed every 2 hours.

25th May 1998

Summary – further deterioration. Syringe driver renewed at 07.00 in some distress when being turned. Syringe driver renewed at 14.55 diamorphine 40mgs.

Code A

Clinical notes – died peacefully at 14.45.

Death verified by Code A

In reply please quote PCH/2000/2047
Please address your reply to the Committee Section FPD
Fax: Code A

COPY

By Special Delivery and First Class Mail

24 September 2004

Code A

Dear Code A

I am writing to notify you that the Code A has considered information received by the GMC about your conduct.

The Code A exercising his powers under rule 4 of the General Medical Council (Interim Orders Committee)(Procedure) Rules 2000, considers that the circumstances are such that you should be invited to appear before the Interim Orders Committee (IOC) in order that it may consider whether it is necessary for the protection of members of the public, or is otherwise in the public interest, or in your own interests, that an interim order should be made suspending your registration, or imposing conditions upon your registration, for a period not exceeding eighteen months, in exercise of their powers under section 41A of the Medical Act 1983 as amended.

The Code A has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved. The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

You are invited to appear before the IOC at **09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you so wish, to address the Committee on whether such an order should be made in your case.

You may, if you wish, be represented by Counsel, or a solicitor, or by a member of your family, or by a representative of any professional organisation of which you may

be a member. You may also be accompanied by not more than one medical adviser. The IOC is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for the attention of Code A **Committee Section (fax no** Code A Code A

You are invited to state in writing whether you propose to attend the meeting, whether you will be represented or accompanied as indicated above, and if so, by whom.

The IOC normally meets in private but you may if you wish, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public. If you wish for the meeting to be held in public could you please notify Code A Committee Section (fax number as above), as soon as possible.

The GMC is under a statutory duty to publish the outcome of IOC hearings. It is our usual practice to do so by placing the outcomes of hearings on our website. If you do not attend the hearing could you please supply Code A (fax number as above) with a telephone or fax number where you can be contacted on the day of the hearing so we can let you know of the decision before placing the information on our website. If you do not provide such a contact number, or we are unable to contact you, the outcome of the hearing will still be published.

If you intend to consult your medical defence society, or to take other legal advice, you should do so without delay.

In accordance with Section 35A(2) of the Medical Act 1983 (as amended), you are required to inform us, within 7 days of receipt of this letter, of the name and address of the following: -

- all of your current employers,
- the Health Authority with which you have a service agreement,
- locum agency/agencies with whom you are registered, and
- the hospital/surgery at which you are currently working.
- If you engage in any non-NHS work, you are also required to notify us, within the same period of time, of the name of the organisation/hospital by which you are employed, or have any working arrangements. Please forward this information directly to me. Upon receipt of these details, your employers will be notified of the Committee's consideration of the matter.
- If you are approved under Section 12 of the Mental Health Act, or Section 20 (b) of the Mental Health (Scotland) Act 1984, you must also notify us of this fact.

I enclose copies of the relevant provisions of the Medical Act, the IOC Procedure Rules, a paper about our fitness to practise procedures and a paper about the procedures of the IOC.

The documents enclosed with this letter may contain confidential information. This material is sent to you solely to enable you to prepare for this hearing. The documents must not be disclosed to anyone else, except for the purpose of helping you to prepare your defence.

Please will you write personally to acknowledge receipt of this letter quoting the reference above.

Yours sincerely

COPY

Code A

Cc: Code A
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ
ISPB/TOC/0005940/Legal

FAO Code A
Committee Section FPD
General Medical Council
178, Great Portland Street
London W1W5JE

Code A

Your Reference PCH/2000/2047

27th September 2004

Dear Code A

re Interim Order Committee hearing on 7th October 2004

I am a Principal in General Practice contracted to Fareham and Gosport Primary Care Trust.

I am on the Bed Fund for Gosport War Memorial Hospital, Bury Road Gosport, administered by the same Primary Care Trust.

I am a partner in the practice of Code A and partners,

Forton Medical Centre,
White's Place
Forton Road,
Gosport PO123JP.

I have no other employment or contract either NHS or non NHS and I am not approved under Section 12 of the Mental Health Act.

I propose to attend the hearing on 7th October 2004. I will be represented by my solicitor Code A of the MDU .

Yours Sincerely

Code A

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

Code A
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: 0207-915-7406

THE MDU

MDU Services Limited
230 Blackfriars Road
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Legal Department of The MDU

Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: mdu@the-mdu.com
Website www.the-mdu.com

Dear Code A

Code A – Interim Orders Committee – 7th October 2004

Further to the letter from Code A to Code A of the 24th September, and indeed our telephone conversation today, can I confirm that I continue to act for Code A

As you know, Code A has previously appeared before the Interim Orders Committee on three occasions. On each occasion the matters raised have been essentially of the same origin and nature.

On each occasion Code A has been represented by Code A of Counsel. The matter is necessarily a little complex and continuity of representation, somewhat unusually for the purposes of such hearings, in this instance is of clear importance. Indeed I would respectfully submit that it would only be reasonable and fair for Code A Code A to have that continuity of representation.

I very much regret to advise you that Code A is unavailable on 7th October. I have made enquiries to see if it might be possible for his existing commitment to be dealt with on another occasion, but understand this is simply not possible.

In these circumstances I would be most grateful if consideration could be given to the provision of an alternative date for the hearing of this matter. I appreciate that the General Medical Council would not seek to delay the matter for any significant period of time, but it may be relevant to observe that at none of the previous three hearings, in June 2001, March 2002 and September 2002 was considered necessary by the Committee to make an Order affecting Code A s registration.

Can I also take the opportunity to point out that the letter to Code A of 24th September, advising her of the forthcoming hearing does not appear to comply with Rule 5 (1) of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000. The letter does not contain a brief statement of the matters which appear to raise the relevant question set out sub sub rule (b).

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

Further, Code A has not yet been provided with any documentation. Curiously, it seems to be suggested that the issue of what documentation will be disclosed has still to be determined. Specifically, in paragraph 3 of the letter from Code A it is said that the GMC is in the process of clarifying with the Police the level of disclosure that can take place. As you will appreciate, Rule 5 (3) of the procedure rules requires that the Registrar shall send a Practitioner copies of any documents received in connection with a case. It is therefore not open to the GMC to be selective – any document received should be disclosed.

I make the points in relation to compliance with Rule 5 (1) and Rule 5 (3) as clearly there are issues to resolve before the matter can reasonably proceed and in those circumstances too brief adjournment might be sensible for all concerned.

I would be most grateful if this application could be given urgent consideration and if I can assist with the provision of any further information, including further details of Code A availability, I will be pleased to do so immediately.

It may assist if I mention now that Code A would be available both on the 13th and 15th October, when I understand the IOC will be sitting to consider cases generally.

Yours sincerely

Code A

E:\Committee\ioc\PHC\2004\[Code A]MDU)290904

Your reference **ISPB/TOC/0005940/Legal**
In reply please quote **ACE/JJC/PCH/2000/2047**

By post and fax – [Code A]

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to the Committee Section FPD
Fax [Code A]

30 September 2004

[Code A]
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear [Code A]

[Code A] **– Interim Orders Committee (IOC) 7 October 2004**

Thank you for your letter of 27 September 2004 in which you request that the Chairman of the IOC consider postponing the scheduled hearing of [Code A]s case in accordance with Rule 7(1) of the Committee's Rules.

I can confirm that the [Code A] of the Committee considered your request and that he did not accede to it.

The [Code A] in considering this request considered the nature and purpose of the IOC, which is namely, to determine whether interim action is required to be taken against the registration of a doctor who may pose a risk to the public, the public interest or their own interests and in fulfilling this function it is considered that the Committee should meet as soon as practicable whilst bearing in mind the need to balance the consequences for the practitioner of the imposition of an interim order and to ensure that the doctor is afforded the opportunity to attend any hearing and be represented, although not necessarily by the Counsel of their choice.

The [Code A] took account of the Council's letter notifying [Code A] of the forthcoming hearing and the timetable contained therein and in reaching his decision considered that the date of 7 October 2004.

In reaching his decision the [Code A] determined that whilst unfortunate that [Code A] [Code A]s chosen Counsel is not available, there was still sufficient time to instruct fresh Counsel to attend and make representations. It is the Council's intention to dispatch a copy of all the papers in the case on 30 September 2004, providing [Code A] [Code A] with 7 days in which to prepare a defence. It was the opinion of the [Code A] that this was sufficient time in which to fully instruct new Counsel to prepare such a defence. The [Code A] further considered that the Council's letter of 24 September 2004 put [Code A] on notice that the hearing would be taking place on 7October

5C

In all the circumstances, the Code A having taken into account your letter of 27 September 2004 and balanced the information contained within against the reasons for Code A 's referral considered that, it was important in the public interest that Code A Code A 's case be heard as soon as possible.

The hearing scheduled to take place on 7 October 2004 will take place as listed and Code A is invited to appear before the IOC at **09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. You are further invited to state in writing whether you propose to attend the meeting, whether Code A will attend and whether she will be represented by Counsel, and if so, by whom.

The IOC normally meets in private but Code A may if she wishes, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Secretariat having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

With regard to your point regarding Rule 5(1)b it is the opinion of the Council that the letter dated 24 September gave the following brief statement of the matters which appear to raise the relevant question set out in Rule 5(1)b:

> *The Code A has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved.*

Further, the Council submits that its letter of 24 September also gives a full explanation as to when Code A can expect to have disclosure of the information to be considered by the Committee, and what information she can expect to be disclosed. The Council is mindful of the provisions of Rule 5(3) but it is not of the view that it's letter contravened those provisions. The letter states that:

The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

The clarification with the Police is in respect of what information the CPS determines can be disclosed to the GMC. The Police are fully aware that any information disclosed to the GMC and subsequently disclosed to any of its Committees must also be disclosed to Code A The Council will disclose to Code A all information that is to be put before the IOC.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

Code A
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: Code A

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Telephone: 020 7202 1500
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Email: mdu@the-mdu.com
Website www.the-mdu.com

Dear Code A

Code A – Interim Orders Committee – 7th October 2004

Thank you for your letter of 30th September, and I am grateful for the provision of written reasons of the decision not to grant adjournment in this matter.

I am grateful too for the observations concerning Rule 5 (1). It remains my contention, however, that the brief statement required by that Rule has not been provided. The information that you quote within the letter is hardly sufficient. There is no basic summary or indication of what the information provided by Hampshire Constabulary might be. Indeed, as I understood the position yesterday no written statement or evidence had been supplied by Hampshire Constabulary to the GMC at that time.

In any event, I am concerned to make further request for adjournment of Code A 's case with the benefit of additional information, and indeed having had the opportunity to consider the written reasons for the Chairman's previous decision.

As you will know, Code A has thus far received no documentation at all in this matter. The statement from the Hampshire Constabulary which it is understood you were to receive yesterday has yet to materialise. Further, I am advised that a significant volume of patient records had been made available to the GMC, which it is felt is not necessary to trouble the Interim Orders Committee but which is nonetheless available. It must be right that Code A has the opportunity to consider those records, which I understand to be some 3 feet deep. It may of course be that there is no information which is necessary to place before the Interim Orders Committee in that regard, on behalf of Code A but unless and until Code A has had the appropriate opportunity to consider the materials, that cannot properly be determined.

Unfortunately, Code A is not immediately able to consider any such documentation even if it were to be made available forthwith. Sadly, Code A have both been profoundly ill recently. Indeed, Code A has only recently been moved from an Intensive Treatment Unit. She will visit them tomorrow and at the weekend. Her first realistic opportunity to look at any amount of documentation would be on Monday of next week.

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

In addition to Code A 's ability or lack of it to consider such a significant quantity of material at this stage, sadly Counsel previously instructed for Code A Code A remains unavailable for the hearing on 7th October. I appreciate at once that the Interim Orders Committee would not ordinarily be concerned to take Counsel's availability into account. However, this matter has previously been considered on three separate occasions by the Interim Orders Committee – and substantively on each occasion, rather than being merely by way of review. There is therefore a long and significant history from which I would submit that it is desirable that there should be continuity of representation, both for Code A herself, and indeed to assist the Committee.

With reference to the limited information given within the letter of the 24th September to Code A about the matter, which you have kindly quoted in your letter to me of 30th September, it is clear that the matter concern the Gosport War Memorial Hospital. Code A Code A ceased to have any involvement with that hospital some long time ago. It must therefore be the case that any matters raised by the Hampshire Constabulary are historical. As best I am aware of it, there has been no expression whatsoever of concern in relation to Code A 's recent practice.

I would respectfully submit that this point is highly relevant in terms of the consideration of the public interest in ensuring that a hearing take place very rapidly. It is also relevant in that regard that on each of the three occasions when Interim Orders Committee has met to consider Code A – on each occasion with reference to the Gosport War Memorial Hospital – the Committee concluded that it was not necessary to make an order affecting Code A 's registration.

Accordingly, there is as best I am aware of it no indication that Code A 's present behaviour gives any obvious cause for concern, and to the extent that her previous activities as a Practitioner have been considered in relation to this very hospital, no action has been taken by the IOC. It must surely be the case in those circumstances that the public interest could not reasonably be adversely affected by an adjournment of a mere week to facilitate both the proper consideration of paperwork and representation by established Counsel.

I would be grateful if my further application for adjournment could be given urgent consideration.

Yours sincerely

Code A
Solicitor

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
5 October 2004

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: mdu@the-mdu.com
Website www.the-mdu.com

Code A
General Medical Council
350 Regent's Place
London
NW1 3JN
BY HAND

Dear Code A

Code A - Interim Orders Committee

I write with reference to your letter to Code A of 30th September 2004. As you will be aware from our various conversations, I represent Code A

In your letter of 30th September you indicated that you had voluminous patient records available to you and that if Code A required a copy of those records you would arrange for her to receive a copy expeditiously.

You will recall that you and I spoke on the 30th September, and I indicated that Code A Code A would indeed wish to have sight of the records. I understood that you would endeavour to make those records available the same day, if not the following day.

We spoke again on the 1st October and you indicated that it had not been possible to copy the notes in view of the lack of facilities brought about the GMC move of offices, which I do very much understand. As I understood it, the records were then to be made available yesterday afternoon, but as you will appreciate, these records have still to arrive.

My expectation is that the medical records concern the patients in relation to whom information is given by the Hampshire Constabulary in purported summaries and expert observations. I remain concerned on behalf of Code A to have access to the medical records, but have to point out that Code A cannot realistically assist the Committee now in relation to any points involving specific patients in circumstances in which she will not have had the anticipated and hoped for opportunity to consider medical material.

I look forward to your response.

Yours sincerely

Code A

RECEIVED
- 5 OCT 2004

In reply please quote PCH/2000/2047

Your ref. ISPB/TOC/0005940/Legal

By Fax and first class post

5 October 2004

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Code A
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Dear Code A

Code A – **Interim Orders Committee**

Thank you for your letter of 5 October 2004, a copy of which I will pass on to Code A Code A in our Committee Section.

I note your comments regarding the medical records and I should inform you that unfortunately, due to the problems experienced by our Reprographics section in the course of our move to our new premises, it is likely that a copy of the records will not be available until tomorrow at the earliest.

I have considered whether it would be prudent to use a commercial reprographics company. However, given the nature of the information, I decided against that course of action.

I will forward a copy of the records to both you and Dr Barton as soon as they are available.

Yours sincerely

Code A

2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 8001 Fax 020 7189 5001
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

SL

E:\Committee\ioc\PHC\2004[Code A]MDU)061004

Your reference **ISPB/TOC/0005940/Legal**
In reply please quote **ACE/JJC/PCH/2000/2047**

By courier and fax – [Code A]

Please address your reply to the Committee Section FPD
Fax [Code A]

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

6 October 2004

[Code A]
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear [Code A]

[Code A] – Interim Orders Committee (IOC) 7 October 2004

Further to your letter of 30 September 2004 and our subsequent telephone and e-mail conversations. I can confirm that the [Code A] *of the Committee did on 1 October 2004 consider your further request to postpone* [Code A]*'s hearing.*

The [Code A] considered that whilst the submissions you made may have force in relation to whether or not the Committee should impose an interim order on [Code A] [Code A]*'s registration it was not for the* [Code A] alone to consider such matters and that in all the circumstances, it was necessary for the reasons given previously and in the public interest that the hearing of [Code A]s case be expedited notwithstanding that her chosen Counsel is not available.

The hearing scheduled to take place on 7 October 2004 will take place as listed and [Code A] is invited to appear before the IOC at **09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** *if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.*

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. I am grateful for your confirmation that [Code A] will be attending the hearing and that she will be represented by [Code A] Counsel.

The IOC normally meets in private but [Code A] *may if she wishes, under the* provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an

adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Code A having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Code A

Confidential
Addendum (II)
Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee
13 October 2004

Information: *Further information:*

1.	Transcript – IOC Hearing – 21 June 2001	**553 – 562**
2.	Expert Review – Catherine Lee	**563**

A

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

B

Thursday, 21 June, 2001

C

Chairman: Code A

D

Case of:

Code A

E

Code A was present and was represented by Code A of Counsel, instructed by Solicitors to the Medical Defence Union.

F

Code A of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council.

G

H

A Code A Sir, this case comes before you under the Conduct procedures. The nature of the case is set out at the beginning of your bundle as, in summary, one of unlawful killing. A police investigation is continuing and has not come to a determination as yet, in relation to whether or not any charges will be brought against Code A

B The papers before you relate to a patient by the name of Code A who was treated at the Gosport War Memorial Hospital in August 1998, where she died. Code A was born on Code A There is a short summary of her medical condition at page 57 from the Royal Hospital Haslar, Gosport, Hants, dated 10 August 1998, written by Code A

C The Committee can see that Code A had sustained a right fractured neck of her femur on 30 July 1998 whilst in the Glenheathers Nursing Home. She was admitted to the ward and had a right cemented hemi-artheroplasty, and was now fully weight-bearing, walking with the aid of two nurses and a Zimmerframe.

D Her past medical history is set out in summary. She was deaf in both ears. She had had cataract operations to both eyes. She had a recent history of falls and was suffering from Alzheimer's, which condition had deteriorated over the previous six months. She had had a hysterectomy in 1955. Her allergies were set out and the drugs that she was currently taking.

The Committee can then see certain details set out as to her day-to-day living.

E Straddling that document is a letter from Code A at pages 56 and 58, dated 5 August 1998. Again, in summary it gives the Committee some information as to Code A standard of health shortly before her death in 1998.

F Sir, the complaint about Code A is brought on the basis of the two statements at the beginning of your bundle. The first is from Code A and the second is from Code A the Code A of the late Code A I ask the Committee to pay attention to those careful, considered and detailed statements in coming to their conclusions today. Those ladies were extremely concerned about the standard of care and attention that was being paid to their Code A while she was under the care of the hospital, and in particular Code A They speak about concerns as to the standards of the care assistants and their attitude towards their mother, and also the standard of care afforded tot heir mother by the nurses at the hospital and their level of communication. They also complained of the level of nourishment and hydration provided to their mother, particularly in the last days of her life.

G It was the wish in particular of Code A be transferred back to the Haslar Hospital, from where she had been transferred to the Gosport War Memorial Hospital. It transpires that that hospital was willing to accept her, but that Code A was reluctant to send her back. What was explained to the ladies shortly before their mother's death was that she had developed a haematoma after the successful manipulation of her hip after it had become dislocated. The suggestion was made at that stage that as she was in so much pain and had been receiving significant pain relief, that she should have some Diamorphine. The reaction of her relative was to

H

A say that that was tantamount to a suggestion of euthanasia, and that was denied by the doctors.

Code A repeated their request that their mother should be transferred. Code A said that that would not be appropriate because Code A had suffered too much trauma for one day already, and that the hospital would seek to keep her pain-free that night.

B

The next morning, on return to the hospital, Code A was told that in effect nothing more could be done for Code A They were told that the appropriate action would be a syringe driver with morphine to ensure that she had a pain-free death.

Their first information to that effect did not come from Code A However, they C did speak to Code A about it. Her attitude was that it was going to be "the kindest way" and that they were to expect as the next thing a chest infection. Certainly Code A and Code A found that that latter comment was extremely insensitive.

It is suggested within the papers and within the medical notes that the daughters accepted the course of action of a syringe driver with the morphine. However, they D maintain that it was something in effect that they submitted to and there was no question of their accepting that course in the knowledge that it would lead to Code A Code A 's death. What they wished was for her pain to be relieved. They believed her to be strong and to be fighting to recover.

It would appear that subsequently the syringe driver was put in place, that Code A Code A received no nourishment in her final days, or indeed hydration. They did not E see a doctor in the days immediately preceding Code A 's death, and certainly at the point of her death there was no doctor present.

I understand that the death certificate refers only to bronchopneumonia and does not refer to the haematoma of which they had been told a couple of days previously.

It was Code A 's opinion that Code A had not been given a proper F chance to make a recovery.

The medical notes begin at page 56. There are nursing notes that are copied on a number of occasions, but it is most convenient to turn to page 239 which shows a nursing care plan for 13 August 1998 through to 19 August 1998. That contains entries in relation to the drugs administered to Code A

G On page 240 there is a contact record, which begins with 18 August 1998. It sets out contact with the family. At one stage Code A is noted as being "quite upset and angry". On the morning of 19 August the Committee will see that Code A were seen. The note reads: "Unhappy with various aspects of care. Complaint to be handled officially." On Code A there is a note: "Patient's overall condition deteriorating. Medication keeping her comfortable. Code A visited during morning." At the top of page 241: "Condition poor. Pronounced dead at H 21.20 hours." The earlier part of that contact record is at pages 242-243.

A Sir, in relation to pain relief there is a note on page 243 that on 18 August 1998 the patient was reviewed by Code A for pain control by a syringe driver, and her treatment was discussed with Code A "They agreed to use of syringe driver to control pain and allow nursing care to be given."

B Code A s notes are copied at pages 222-223. The Committee may find some of them difficult to read. We have the benefit of a police statement by Code A however, in which she sets out the substance of some of those notes in typewritten form. The Committee will note in particular the note in the form of a rhetorical question: "Is this lady well enough for another surgical procedure?" That was made on 14 August 1998. Turning the page, the Committee will see on 18 August the first note, "still in great pain" continuing, "I will see Code A today; please make comfortable". On 21 August: "Much more peaceful" or "restful" and there is a C reference to a drug being given for her chest. The pronouncement of death is recorded again at the bottom of that page.

The doctor's statement provided by the Hampshire police is at the back of the document. The Committee will have regard to that in coming to their conclusions. In essence, Code A refutes any allegation of wrongdoing in her care of Code A in the days leading up to her death.

D Sir, it may be suggested that there has been significant delay in this matter coming before you. The statements of Code A and Code A that were provided to us by the police were not forthcoming until 6 June 2001, as can be seen from page 6. This matter comes before the Committee at the first possible opportunity subsequent to the information being provided to the General Medical Council.

E It is my submission that in this case it would not be appropriate to consider conditions on the doctor's registration; that in essence the facts in the papers raise such a significant concern about this doctor that this Committee ought to consider suspending her registration on an interim basis.

Code A The events took place in August 1998. Do we have any information about when the inquiry commenced?

F

Code A I understand that there was an initial investigation by the police which was concluded, and no action was taken at that time, on the advice of the Crown Prosecution Service. I know not the basis for that advice. Subsequently a complaint was made about the conduct of that investigation by Code A Code A and the matter has subsequently been re-investigated.

G Code A Is it the second investigation that is being referred to in the letters at pages 4 and 5?

Code A Yes.

Code A The statements were taken in January and March 2000 by the police. The letter of 27 July on page 4 indicates that the investigation is H ongoing and no charge is preferred. The letter at page 5, dated 20 September, says

A that the investigation is ongoing and that a file will be submitted to the Crown Prosecution Service as soon as possible. The outcome was estimated to be unknown for three or four months. We are now a considerable distance ahead of that period. Are you aware whether a file has been submitted to the Crown Prosecution Service?

Code A I understand that it is within their remit, but no decision has been taken.

B

Code A Do you know whether or not, in the course of their investigation, the police have sought and obtained independent medical evidence to determine whether their case can be substantiated?

Code A Sir, we have provided the Committee with the evidence that was before the screener, and that is the only evidence that I have had sight of.

C

Code A Can I deal with those queries now, because I have some information. You have been told that the Code A complained. They did complain; they complained about almost everybody. I put the facts baldly and try not to put any gloss upon it. You will see that they complained about the nursing home where Code A Code A was, long before she came under Code A s care. They complained about the first hospital. I do not think all the members of staff were complained about, but some of them were. They complained about this hospital where Code A had charge of this patient.

D

The allegation appears to be a conspiracy to murder. It appears that everyone has put their heads together in looking after this elderly lady and agreed not to feed her and to give her a grossly excessive course of treatment. Code A complained to the police and the police conducted an investigation, and that resulted in no action being taken. They then complained about the police who had conducted an investigation, and a second investigation has commenced. We do not have a result of that investigation. Those instructing me act for Code A in the criminal investigation, and we therefore know that within the next few weeks there is to be a meeting between the police and the prosecution service and Treasury counsel instructed to advise the CPS, at which time we are told a decision will be taken. We know that expert opinion has been sought by those who investigate this matter. We have not seen a copy of the expert opinion, nor do we know what that opinion contains. We are certainly concerned at a very considerable delay. That is the background.

E

F

The first point I make on Code A s behalf is that, plainly, there is no conceivable basis here for suggesting that the drugs that were prescribed and administered to this lady were inappropriate. There is no basis at all for saying that the level of drug prescribed was excessive for this patient. There was no basis for arguing that the Diamorphine that was prescribed and administered caused the death. Similarly, in relation to the hydration and the other aspects of care provided to this patient, there is no basis for saying that what was provided was inappropriate. There is no medical opinion, and there is no argument either that any failure to hydrate this lady caused her death. The Code A suggest that it was their understanding that the haematoma could have caused death.

G

H

A I do not mean to criticise Code A at all. Plainly, they were extremely fond of their mother and they were anxious to do everything that could possibly be done for her. It may well be the case – as I know Code A would say – that they were unable to accept that Code A was terminally ill, and they did not accept it. They believed that Code A would remain alive and continue to live. It would seem that they blamed those around Code A for failing to maintain her and keep her alive.

B It is clear from the medical records that this lady was in poor shape and was deteriorating. There has been no conspiracy by medical staff or the nursing staff, the charge nurse, or those others who were responsible. There is no conceivable basis for saying here that there is a *prima facie* case and that those responsible on a day-to-day basis caused this lady's death, or brought it about.

C This case may have been brought here prematurely. We suggest that it should not have been brought here at all. There may be, at some stage in the future, if there is an opinion of an expert in palliative care or terminal care, an argument that there were failures in Code A 's care of this patient, but on the evidence you have seen there is no basis for such a proposition at all.

D Page 266 is Code A 's statement, which was provided by her when she was spoken to by the police. She was one of quite a number of people who were spoken to by the police and she was in no different position from the other people responsible for this lady's care. You will see Code A 's position, qualifications and experience. She qualified in 1972. She became a partner in her present practice in 1980. In 1988 she took up the additional post of Code A in elderly medicine on a part-time sessional basis. She was working at the Gosport War Memorial Hospital. She retired from that position last year. Obviously, this statement dates from 2000.

E Her present situation is stated in paragraph 3. She is also the present Code A of the Gosport Primary Care Group.

F She was carrying out five Code A sessions at the Gosport Hospital. As you will see from paragraph 4, she would attend the hospital every weekday morning at an early hour and engage in two formal ward rounds with the Code A geriatrician. She would do that before she went to treat her patients in her general practice. She did not have constant attendance at hospital. She was not in a position to review at short notice this lady's condition. It is a misunderstanding on the part of Code A to the extent that they suggest that Code A was there and able to assist and deal with matters as and when they arose.

G As far as the doctor's present position is concerned regarding opiates, she does not continue to work as a Code A at this hospital. She has not prescribed Diamorphine for over a year. The last time she prescribed an opiate of any kind in palliative care was Fentanyl, and that was for a patient who was being nursed intensively. She does prescribe morphine sulphate tablets for her own patients, but obviously only when it is appropriate.

H There is no basis here for saying that the prescription of an opiate for this lady was excessive or inappropriate.

A

Page 21 is the statement of Code A who was herself a Registered General Nurse.

> "I have had sight of a report prepared by Code A and dated 22 December 1998, which has attached to it a Hampshire Constabulary exhibit label "

B

She goes on to say a few things about the report and, if I can use this phrase, she tries to pooh-pooh it. She says that the report appears to have been prepared by reference some time after the event to information, notes and documents supplied by colleagues with whom she worked on a regular basis. Can I show you this report, because this was the consultant under whose care this lady was admitted? It provides a commentary on two aspects of the case with which you may be concerned: (1) the use of a syringe driver and the prescription of Diamorphine; (2) the provision of

C

fluids for this lady. (Same handed to members of the Committee)

Sir, you and your colleagues will have seen the suggestion that one of the sisters believed the use of Diamorphine was merely to accelerate the death, that Diamorphine was to be used for euthanasia. They raised that proposition, it would seem.

D

> Code A asked the Code A 'Are we talking about euthanasia? It is illegal in this country, you know.' The Code A replied: 'Goodness, no, of course not.'"

Diamorphine has a perfectly proper use and is used very commonly in terminal care.

E

The second proposition raised by Code A is that the use of a syringe driver for Diamorphine was foisted on them and they were unhappy with it. There were discussions. One would hope that there will be discussions between the nursing and medical staff and the relatives, so that agreement can be obtained as to a proper and therapeutic approach. It is clear from the documentation to which you have been referred that there were such discussions. It is regrettable that Code A were later to say that they did not really agree, but you have been given the references at page 243.

F

The true situation is that, clearly, there were discussions with Code A and they were perfectly proper discussions. There is no basis for saying that this drug should not have been given or given at that level.

G

In relation to fluids, you have the opinion of Code A You have Code A 's position stated at some length in the statement at the end of the bundle, which I know you will have read. The decision that was taken in this case, I suggest, was an entirely proper one. There is no basis here for suggesting that it was gravely improper or that it departed from proper medical practice. It is perhaps unfortunate that Code A did not understand, or were later to say that they did not understand or agree with the decision, but it is clear from the records that there were regular discussions between those nursing this lady and the medical staff as to how she should be treated.

H

A As to the decision not to transfer this elderly and demented lady back for a third transfer to the Haslar Hospital in a very few days, there is no basis for saying that that was a wrong decision or one that did not have her best interests at heart – it plainly did. The report of the Code A clearly bears out the approach that Code A took.

B There is no conceivable basis for alleging that any actions by Code A in prescribing or causing to be administered the Diamorphine, caused the death. There is no basis for saying that anything she did reduced the quality of life of this lady or shortened her life. There is no basis for saying in this case that there should be a suspension. I do not deal with the question of conditions. Clearly, conditions have not been asked for. In any event, Code A no longer works in this unit, and I have given you her present situation as far as opiates are concerned.

C Code A I notice that Diamorphine was given in the dosage of 40 mg and the patient was on 45 mg of Morphine prior to that. I know that pain control was not too good, but the day the 40 mg of Diamorphine was started it was equivalent to 120 mg of Morphine, which was three times the dosage. What was the dosage that she was on, on the 21st?

D Code A I think it was the same. There is a record within this bundle.

Code A There is no mention of dosages anywhere, as to whether it was increased or decreased from 14 August.

Code A It was not decreased. There is a record here. There is a prescription sheet, but I do not have a page number. That shows the administration.

E Code A Who had the ultimate legal responsibility in Gosport Memorial Hospital? Is there a Code A involved?

Code A They are Code A beds.

Code A How often does the Code A do a round?

F Code A I think the position may have changed since 1998, but Code A 's statement says that there were two Code A ward rounds a week.

Code A We are talking about 1998. Who carried the ultimate clinical responsibility of those beds?

G Code A whose statement you have just read, had responsibility for the patient. She was on study leave for the last three days of Code A life but she carried out weekly war rounds prior to that.

Code A The Code A sheet shows that it is two sessions weekly.

Code A It is page 266. It was five Code A sessions.

H Was any junior doctor involved?

Code A There are no junior doctors. It is just me.

Code A Going back to what I was saying, now that I have had a chance to read it properly, the Diamorphine was 40 to 200 mg (page 254), which is a very big jump of medication. Who authorised it and how was that done?

Code A : The dosage was reviewed every morning, and if an increase was necessary, it would be put up – obviously not straight from 40 to 200 mg but in 20 mg steps until the patient was comfortable. As it turned out, it was not necessary. Code A needed no increase from the 40 mg initially put.

Code A The nurses were not left to increase the dosage; it was by an of the doctor.

Code A Yes.

Code A Sir, the Committee can only act if they are satisfied either that it is necessary for protection of the members of the public, or otherwise in the public interest, or in the interests of the practitioner that an order be made under section 41(A)(i) of the Medical Act 1983. Before you, the Committee, can be so satisfied in any case, it is necessary to find that the evidence before you amounts to a *prima facie* case supporting interim action on one or more of the grounds that I have just referred to. In this particular case, I simply draw to your attention the absence of any independent specialist medical expert opinion indicating fault of any kind on the part of Code A which is obviously something you will have to take into account in considering the question of whether or not there is a *prima facie* case here suggesting fault. If you find that you are so satisfied in respect of any one or more of those grounds, then you must decide whether to make an order attaching conditions to the registration or suspending that registration in either case for a period not exceeding 18 months.

Code A Might I add one point, which I should have raised? Those instructing me did make inquiries of the GMC about this case. I know that the screener, when he or she looked at the papers in this case, did not have Code A 's statement to look at. It was provided by the police at a date after the screener had looked at these papers, so all the screener saw was the statements of the Code A and the medical records.

Code A My understanding is that the police statement at page 266 came in with the fax header sheet that was received dated 12 June this year (page 265) and that is the date after which the screener screened the matter. My understanding and my instructions are that the screener did have the statement of Code A

Code A We are dealing with all the documents before us, which include Code A 's statement. We will give due weight to all the documentation we have.

Code A We have received a letter from the Fitness to Practise Directorate dated 19 June. Of course, I will check with my learned friend, but we have raised in correspondence the question of whether the screener saw Code A 's statement, and

we were told that the screener, in reaching his decision, considered the documentation that was supplied to us by the police on 6 June 2001 and which was served on Code A 's statement was received at a later time than that.

Code A In any event, as the Code A has made clear, this Committee considers all the material matters before it and is not in any way bound by the fact that the screener has decided to refer the case to the Committee.

Code A I raise it for the sake of completeness, for no other reason.

STRANGERS THEN, BY DIRECTION FROM THE Code A WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA

DECISION

Code A the Committee have carefully considered all the evidence before it today.

The Committee have determined that they are not satisfied it is necessary for the protection of members of the public, in the public interest or in your own interests that an order under section 41(A) of the Medical Act 1983 should be made in relation to your registration.

Expert Review

Code A

No. BJC/31

Date of Birth:

Date of Death: Code A

Code A was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Haslar Hospital where she had been admitted for surgery to repair a fractured neck of femur.

On admission, it was noted that Code A had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing.

On admission she was settled on the ward and given oral Morphine.

This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May.

She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam.

The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.

Diazepam 2mg Usual GP

None of the prescriptions under other Drs names have been written by Code A

USUAL DR: Code A

Surname	First Names	NHS NumberD.O.B	Number
-------	----------	----------	------

Code A

USUAL DR: Code A

Surname	First Names	NHS NumberD.O.B	Number
-------	----------	----------	------

7

Code A

JSUAL DR: Code A

Surname	First Names	NHS NumberD.O.B	Number

Code A

USUAL DR: Code A

Surname	First Names	NHS NumberD.O.B	Number

Code A

Code A

USUAL DR: Code A

Surname First Names NHS NumberD.O.B Number

Code A

USUAL DR: Code A

Surname First Names NHS NumberD.O.B Number

Code A

Code A

Total: 150

MG11T

HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

Home Address:

Post Code :

Home Telephone No: **Mobile / Pager No:**

E-Mail Address *(if applicable and witness wishes to be contacted by e-mail)*:

Contact Point *(if different from above)*:

Address:

Work Telephone No:

Male ☐ **Female** ☐ **Date and Place of Birth:** Place

Maiden name: **Height:** **Ethnicity Code:**

State dates of witness non-availability:

I consent to police having access to my medical record(s) in relation to this matter	**Yes** ☐ **No** ☐ **N/A** ☐
I consent to my medical record in relation to this matter being disclosed to the defence	**Yes** ☐ **No** ☐ **N/A** ☐
The CPS will pass information about you to the Witness Service so that they can offer help and support, unless you ask them not to. Tick this box to decline their services.	☐

Does the person making this statement have any special needs if required to attend court and give evidence? *(e.g. language difficulties, visually impaired, restricted mobility, etc.).* **If 'Yes', please enter details.**	**Yes** ☐ **No** ☐
Does the person making this statement need additional support as a vulnerable or intimidated witness? If 'Yes', please enter details on Form MG2.	**Yes** ☐ **No** ☐
Does the person making this statement give their consent to it being disclosed for the purposes of civil proceedings *(e.g. child care proceedings)***?**	**Yes** ☐ **No** ☐

Statement taken by *(print name)*:

Station:

Time and place statement taken:

Signature of witness: .....

Signed : Code A Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

Age if under 18: *(if over 18 insert 'over18')* **Occupation:**

This statement (consisting of page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature: ..... **Date:** 30TH September 2004.

Tick if witness evidence is visually recorded ☐ *(supply witness details on rear)*

I am Code A, Head of Hampshire Constabulary Criminal Investigation Department and am the senior investigating officer in respect of a police investigation named 'Operation ROCHESTER', an investigation into the circumstances surrounding of death of 88 patients occurring principally during the late 1990's at Gosport War Memorial Hospital, Hampshire.

This investigation followed allegations that during the 1990's elderly patients at Gosport War Memorial Hospital received sub optimal or sub- standard care, in particular with regard to inappropriate drug regimes, and as a result their deaths were hastened.

The strategic objective of the investigation is to establish the circumstances surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service (CPS), to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths.

During the investigation, a number of clinical experts have been consulted.

Signed : Code A Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

On the 9th November 2000 Code A reported on the death of a patient, Code A

On the 12th February 2001 Code A reported in respect of the deaths of five patients Code A Code A and Code A

On the 18th October 2001 Code A reported on the deaths of patients Code A Code A

The aforementioned reports have all previously been made available to the General Medical Council.

Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths, and concluded that, "a number of factors contributed to a failure of trust systems to ensure good quality patient care".

Between September 2002 and May 2004 the cases of 88 patients including those named above, at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxicology, general medicine, palliative care, geriatrics and nursing.

Signed : Code A Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

All the cases examined were elderly patients (79 to 99yrs of age) theirs deaths occurring at Gosport War Memorial hospital between January 1996 and November 1999. A common denominator in respect of the patient care is that many were administered Opiates authorized by Code A prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patients concerned, examining in detail patient records, and to attribute a 'score' according to their findings against agreed criteria. A further group of cases were included in this review following a report by Code A commissioned by the Code A That report is confidential to the Code A and may not be discussed further without his agreement.

The team of experts has 'scored' the cases as follows.

Category one- There were no concerns in respect of these cases upon the basis that 'optimal care' had been delivered to patients prior to their death.

Category two - Specific concerns that these patients had received 'sub optimal' care.

These cases are currently undergoing a separate quality assurance process by a medico legal expert to confirm their 'rating'. Nineteen of these cases that have been 'confirmed', have been formally released from police investigation and handed to the General Medical Council for their consideration. A number of cases

Signed : Code A Signature witnessed by : _____

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URN //

Statement of : Code A

have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.

Category three Patient care in respect of these cases has been assessed as 'negligent, that is to say outside the bounds of acceptable clinical practice'.

The police investigation into these cases is, therefore continuing.

The five experts commenced their analysis of patient records in February 2003. It is anticipated that their work will be finalized in October 2004 as will the quality assurance process by medico legal expert.

As part of the ongoing investigative strategy, since May 2004 a further tier of medical experts, in Geriatrics and Palliative Care have been instructed to provide an evidential assessment of the patient care in respect of in the 'Category three' cases. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service.

At the same time, the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness/suspect interviews, deal with exhibits, complete disclosure schedules, and populate the major crime

Signed : Code A Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

investigation 'Holmes' system a national police IT application used to record and analyze information relating to serious/complex police investigations.

To date 330 witness statements have been taken and 349 officer's reports created. 1243 'Actions' have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of the Hampshire Constabulary.

Whilst investigations will be fully completed in respect of all of the 'Category three' cases, a small number of sample cases have been selected and work is being prioritized around those with a view to forwarding papers to the CPS as soon as possible by way of expedition. Timescales for this action are clearly dependant upon completion of expert review of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process,

In the event that there is considered a sufficiency of evidence to forward papers to the CPS, it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.

I understand that the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Order Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee.

Signed : Code A Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

In my view, this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professionals involved in this enquiry.

Police investigative interviewing operates from seven basic principles, which are laid out in Home Office Circular 22/1992. The first of these being that

"Officers seek to obtain accurate and reliable information from suspects, witnesses or victims in order to discover the truth about matters under police investigation."

Investigative interviewing should be approached with an open mind. Information obtained from a person who is being interviewed should always be tested against what the interviewing officer already knows or what can be reasonably established.

This investigation is currently following various lines of enquiry seeking to establish whether or not any criminal offence has been committed. At present it has not been established that this is the case or in fact whether or not any person is potentially culpable. Once an individual has been identified then decisions have to be made as to what they need to be interviewed about and what information it is proper to disclose to that person prior to their being interviewed.

Decisions as to what the police have to disclose prior to interviews under caution are covered by various aspects of case law, in particular R v Argent (1997). The court commented in this case that the police have

Signed : Code A Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

no obligation to make disclosure. In R v Imran and Hussein (1997) the court agreed that it would be wrong for a defendant to be prevented from lying by being presented with the whole of the evidence against him prior to interview.

R v Mason (1987) covers disclosing or withholding information, the process must be justifiable and conducted in the full knowledge of the likely consequences. These consequences could affect not only any subsequent interview but also potentially the whole investigation and any subsequent trial.

Article 6 Human Rights Act deals with the right of an individual facing criminal charge to have a fair and public hearing

Advance disclosure of documentation prior to interviews under caution gives any potential suspect the opportunity to interfere with the interviewing of other witnesses who may have information beneficial to the case.

Furthermore the suspect does not have the opportunity to respond to questioning in an uncontaminated way. They may well respond with answers that they think the police wish to hear. This is unfair to the individual concerned.

Finally early disclosure of material can lead to a suspect fabricating a defence or alibi.

Signed : Code A Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

The Police have an over riding responsibility to conduct an effective and ethical investigation and a have a legal and moral duty to be scrupulously fair to suspects. In addition the police carry an additional responsibility to representing the interests of the victims of crime and society in general. Therefore to provide a guilty suspect with the ability to fabricate a defence around police evidence does not serve those wider interests.

As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case.

I understand that there is a voluntary agreement in place between Code A and the Fareham and Gosport Healthcare Trust of November 2002, the following is a quotation from an e mail message to the investigation from the trust in respect of that matter.

Code A has undertaken not to prescribe benzodiazepines or opiate analgesics from the 1st October 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.

Code A will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health-call as a prescription may be required for a 14 day supply of benzodiazepines for bereavement.

Code A also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patient's notes.

Signed : Code A Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

During a 13month periods from April 2003 Code A ***had written a total of 20 prescriptions all for 2mg diazepam to relatives of deceased and had not prescribed any diamorphine, morphine or other controlled drug.'***

I have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim order committee during September 2002.

Code A this has been assessed as a category three case and is being investigated accordingly.

Code A - again a category three case.

Code A Assessed as a category two case by the clinical team, this assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004.

Code A – No further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points;

1. There is no admissible evidence at this time of criminal culpability in respect of any individual.
2. The information adduced by the investigation thus far, and the findings of the experts lead me to have concerns that are such that, in my judgment the continuing investigation and the high level of resources being applied to it are justified.

Signed : Code A Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

Signed : Code A

Signature witnessed by : _____

Code A

The Guardian
14 September 2002
Page 2

Inquiry launched into 'suspicious deaths' at hospital

John Carvel
Social affairs editor

The government yesterday launched a special inquiry into the suspicious deaths of elderly people at a cottage hospital in Gosport, near Portsmouth, after relatives complained that there may have been at least nine unlawful killings.

Sir Liam Donaldson, the chief medical officer, has called in Richard Baker, a professor at Leicester University, to conduct a clinical audit of services for older people at the Gosport War Memorial hospital.

Prof Baker was the expert appointed by the Department of Health to investigate the practice of Dr Howard Shipman after his conviction as a serial killer. His finding that Shipman might have been responsible for 330 deaths persuaded ministers to expand a public inquiry into his crimes.

Officials were last night unaware of the government launching any similar clinical audit before a prosecution and conviction.

Police investigated the hospital between 1998 and 2001 after concern among relatives about the death of an elderly woman who was prescribed diamorphine. This led to allegations about the deaths of eight other patients.

Hampshire police sent papers to the crown prosecution service, which decided there was not sufficient evidence on which to base a prosecution, according to a Department of Health spokeswoman.

The commission for health improvement (CHI), the government's hospital inspectorate, said: "The police were sufficiently concerned about the care of older people at the hospital to share their concerns with us."

The CHI found there was systematic failure to provide good quality care, including insufficient guidelines on prescribing painkillers and sedatives, inadequate review of prescribing for older people and lack of supervision.

In a report in July it said: "CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998."

The inspectors were "unable to determine whether these levels of prescribing contributed to the deaths of any patients". But it was clear that this level of prescribing would have been questioned if adequate checking mechanisms had been in place.

"Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001."

However, the inspectors said they had no serious concerns about current standards.

Sir Liam's decision to mount an investigation was based on uneasiness that neither the police nor the inspection team "was in a position to establish whether trends and patterns of death were out of line with what would be expected". Inquiries of this kind are extremely unusual, officials said.

The original investigation was sparked when Gillian Mackenzie of Eastbourne, East Sussex, contacted police about the death of her 91-year-old mother in 1998.

She said at the time: "I am a realistic woman. I knew there was a chance of my mother dying when she was admitted to hospital. It is the manner she died that shocked me.

"I will never know what would have happened if she had not been prescribed diamorphine, but we must ensure that all the circumstances of these deaths are fully explained."

The Daily Telegraph
14 September 2002
Page 8

CPS to look at hospital deaths

A third inquiry into the deaths of elderly patients at a cottage hospital was announced yesterday as police said they were sending new evidence on four of them to the Crown Prosecution Service.

Nine elderly people died at Gosport War Memorial Hospital, Hampshire, amid allegations of unlawful killing and over-use of pain-killing drugs. Police are in touch with the General Medical Council and the Commission for Health Improvement.

Police first investigated the case of a 91-year-old woman. Officers were then contacted by eight other families.

The Sunday Times
15 September 2002
Page 5

Police probe 13 hospital deaths

Lois Rogers
Medical Correspondent

POLICE are investigating the deaths of 13 elderly hospital patients who relatives believe were killed with overdoses of powerful drugs, including the painkiller diamorphine.

On Friday Liam Donaldson, the chief medical officer, ordered an audit of the hospital's death rates, which will be carried out by the same expert who analysed mortality among patients of the GP Harold Shipman.

Shipman, who was sentenced to life two years ago, is believed to have killed more than 250 elderly people by giving them overdoses of diamorphine, the pure form of heroin that is used as a painkiller but is lethal in overdose.

All 13 of the Hampshire patients were admitted to Gosport War Memorial hospital between 1997 and 2000 to recover from various operations and treatments. None of their families was told at the time of admission that their relatives were expected to die.

Jane Barton, a GP who was in day-to-day charge of medical care at the hospital until July 2000, was referred to the General Medical Council's professional conduct committee last week. A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

However, there is no suggestion that Barton, who has refused to comment, or any of the others who worked on the wards deliberately caused harm to any patient.

Among the cases being probed are the deaths of:

- Elsie Devine, 88, who was admitted to the hospital to recover from a kidney infection. Her relatives were urged to leave the hospital shortly before she died. They were stunned to discover she had been given large doses of diamorphine.
- Leonard Graham, 75, who was recovering from pneumonia. His wife was "told" to ring her daughter while a drug dose was administered. He died shortly afterwards.
- Betty Rogers, 67, who was recovering from a chest infection. Her daughter was urged to go home having been told her mother was not near death. Fifteen minutes later she received a call saying she had died.

Other deaths under investigation include Stanley Carby, 65, Eva Page, 88, and Dulcie Middleton, 85.

Among those who are helping the police with their inquiries is Jim Ripley, a 76-year-old gout sufferer who was admitted to Gosport War Memorial hospital in April 2000. He narrowly escaped death after falling into a painkiller-induced coma on one of the three wards now under investigation. It took five hours for an emergency doctor to arrive after he lost consciousness at hospital. He was transferred to the nearby Haslar hospital where staff soon established he had not had a stroke, as was first suspected, but was in an "analgesic coma".

A number of families were advised to take holidays during their relatives' last hours. "Why did they tell me to go on holiday? Surely they knew he was going to die," said Dorie Graham, whose husband Leonard died in 2000. She complained to the police more than a year ago.

Edna Purnell, 91, entered the hospital for rehabilitation after a hip replacement. She was put in a darkened room and heavily sedated, according to Mike Wilson, her son. Wilson consulted a solicitor and tried to get her moved to a private hospital. He was then himself rushed into hospital after a heart attack and while he was there she died.

The medical notes of Alice Wilkie, 88, record her as having died twice on the same day. Her granddaughter Emily Yeats believes this is because her files were mixed with those of Gladys Richards, 91, who died hours later. Both received cocktails of painkillers that investigations by the Commission for Health Improvement (CHI) revealed should not have been used together.

A CHI report into the hospital's practice, published in July, criticised the use of diamorphine combined with a strong anaesthetic, and another drug usually used to treat schizophrenia. This combination, the report said, "could carry a risk of excessive sedation and respiratory depression in older patients, leading to death".

The CHI was originally asked to investigate the hospital by the police, who had begun a criminal investigation into the 1998 death of Richards, after her family alleged she had been unlawfully killed.

Although the CHI report said it could not look at any particular death, it found doses of up to 200 milligrams a day of morphine were being administered through pumps into patients' bloodstreams. Prescriptions for morphine and other potent drugs were regularly written in advance, so that nurses could administer them unsupervised.

Ian Piper, the chief executive of the Gosport and Fareham primary care trust, which now administers the hospital, said he could not comment on individual cases. The trust has just sent its first draft of proposals to meet the 22 recommendations for change in the CHI report. Standards of care at the hospital had improved, said Piper.

Families of 10 of the dead patients attended a meeting called by Ian Readhead, deputy chief constable of Hampshire, last week. Police said a file on the affair will be sent to the Crown Prosecution Service this month. The Nursing and Midwifery Council said it was investigating disciplinary proceedings against several nurses.

Donaldson has commissioned Richard Baker, professor of clinical governance at Leicester University, to repeat the statistical analysis he conducted into Shipman's practice.

Donaldson said previous inquiries into patient concerns at Gosport had not established whether patterns of death were "out of line with what would be expected". Baker will seek to answer the question fully.

News of the World
15 September 2002

New old folks death probe

THE professor who investigated serial killer Dr Harold Shipman is to head a probe into hospital deaths.

Richard Barker will lead the third inquiry into the deaths of at least eight elderly patients at Gosport War Memorial Hospital, Hants.

Code A

Daily Mail (Late)
16 September 2002
Page 19

Shipman case expert heads hospital probe

AN expert who worked on the case of mass murderer Harold Shipman is to head an inquiry into the deaths of 13 patients at a hospital.

There are fears that some who died at Gosport Royal Memorial Hospital in Hampshire between 1997 and 2000 may have been killed by a drug overdose.

Files on several of the cases are being sent to the Crown Prosecution Service although there is no suggestion that any of the patients was harmed deliberately.

The investigation began after families raised concerns that their relatives may have been given overdoses of drugs including diamorphine.

Professor Richard Baker of Leicester University has been commissioned to study the deaths. He analysed death rates at GP Harold Shipman's practice in Hyde, Greater Manchester.

Shipman is serving life for murdering 15 patients but has been blamed for killing 200 more.

Code A

The Times
7 November 2002
Page 3

Shipman-style inquiry into 50 deaths at hospital

By Michael Horsnell and Russell Jenkins

AN EXPERT in the use of diamorphine, the heroin-based painkiller, is to be appointed by police conducting an investigation into the suspicious deaths of more than 50 elderly patients at a community hospital.

Relatives allege that the drug, used by Harold Shipman to kill many of his patients, was over-prescribed at the Gosport War Memorial Hospital in Hampshire. Detectives are preparing to interview relatives of those who died at the 180-bed hospital amid claims of unlawful killing.

Many patients died while receiving recuperative care under a regime in which prescriptions for morphine and other potent drugs were regularly written in advance so that nurses could administer them unsupervised.

Ann Alexander, a solicitor who represented more than 300 families in the Shipman inquiry, had a two-hour meeting with Detective Chief Superintendent Steve Watts of Hampshire police and his deputy Nigel Neven yesterday.

She said: "It was a very productive meeting. They have completely reassured me about their intentions to do whatever they can to get to the bottom of whatever has been going on at this hospital."

After complaints by some relatives that police had failed to respond fully to initial concerns, it was disclosed that officers will examine how Greater Manchester Police put together the Shipman inquiry, notably its use of expert witnesses. Ms Alexander said: "Police want to see every single family that wishes to see them. They are hoping that anyone who has not been in touch and who has concerns should come forward."

The meeting, at her office in Altrincham, Greater Manchester, came after worried families contacted a helpline established by health managers. A total of 57 people attended a public meeting held by Alexander Harris, solicitors, on Sunday to hear concerns about treatment at the hospital dating back to the early 1990s.

The law firm represents relatives of 27 elderly patients who died at the hospital and one who survived, but there are believed to be at least as many again whom detectives want to contact.

Among the cases under investigation are those of Leonard Graham, 75, who was recovering from pneumonia. Another, Betty Rogers, 67, was recovering from a chest infection. Her daughter was urged to go home, having been told her mother was not near death. Fifteen minutes later she received a call saying her mother had died.

Other deaths under investigation include those of Stanley Carby, 65, Eva Page, 88, and Dulcie Middleton, 85.

The hospital has already been the subject of an investigation by the Commission for Health Improvement, which criticised its prescribing practices. Althought a commission report said that it could not look at any particular death, it found doses of up to 200 milligrams a day of morphine were being administered by pumps.

In September the government's chief medical officer commissioned a clinical audit. Professor Richard Baker, who worked on the Shipman inquiry, was appointed to examine death rates at the hospital.

In the same month the chief executives responsible for managing the hospital at the time of the deaths were suspended. Ian Piper, of Fareham and Gosport Primary Care Trust, and Tony Horne, of East Hampshire Primary Care Trust, were redeployed to other duties. The suspensions were prompted after internal documents from 1991 — prior to the deaths — were uncovered which highlighted concerns about prescribing practices at the hospital. The hospital has moved to reassure current patients by appointing an experienced senior nurse from another area to oversee and review patient care.

Jane Barton, who was in charge of the day-to-day treatment of some elderly patients at the hospital until July 2000, was referred to the General Medical Council in September. A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

There is no suggestion that Dr Barton, who has refused to comment, or any of the others who worked at the hospital, deliberately caused harm.

The Hampshire and Isle of Wight Health Authority said: "It is important to note that whilst the CHI investigation had some serious concerns about services in the past, it concluded that policies and procedures are now in place to ensure safe standards of care at the hospital."

Hampshire police said: "Detective Chief Superintendent Steve Watts today had a meeting with Alexander Harris in Altrincham who are representing the families of people who died at the Gosport War Memorial Hospital. Senior members of his investigating team were at the meeting. The investigation is ongoing."

The Times
7 November 2002
Page 3

Relatives tell of their anguish

Case History 1:

ANNE REEVES would have looked after her mother at her home in Fareham, Hants after the elderly widow completed successful treatment for a kidney infection at Queen Alexandra Hospital, Portsmouth.

But her own husband was also in hospital, having a bone marrow transplant for leukaemia. So it seemed a sensible idea for Elsie Devine, 88, to recuperate at the War Memorial Hospital in Gosport. She died on November 21, 1999.

Mrs Reeves said: "She had been doing very well. Then on November 19 my brother Harry visited and was met by Jane Barton who said mother was in kidney failure and had 36 hours to live.

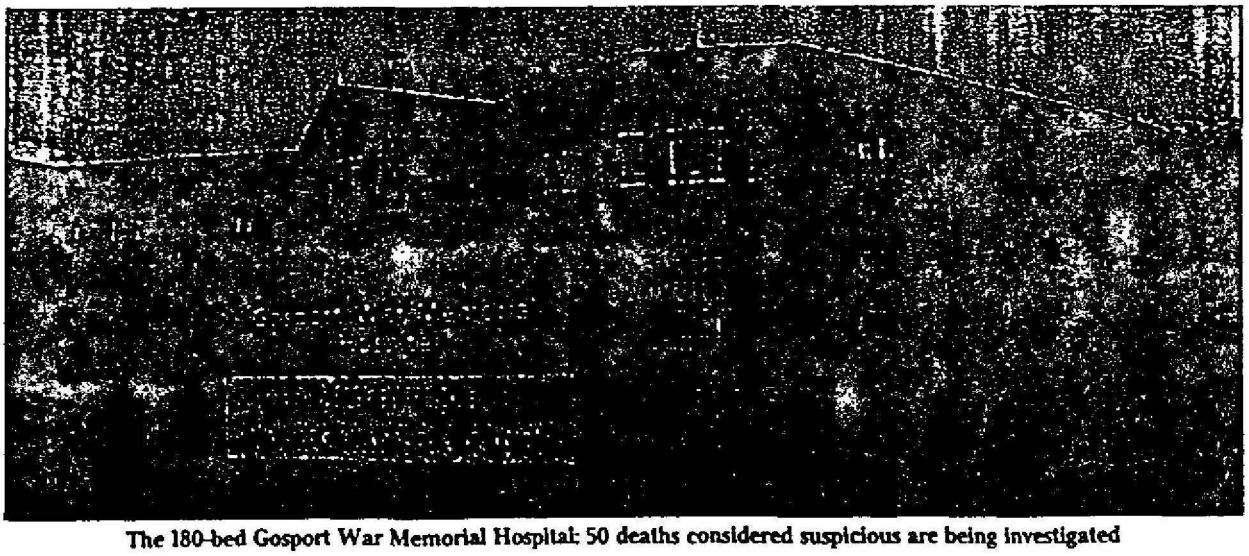
"She couldn't speak and couldn't open her eyes. She was just lying there."

Mrs Reeves, who has obtained her mother's drug charts, added: "She had been put on a cocktail of sedatives and, in the end, it killed her. I don't know why, because she wasn't in any pain."

Case History 2:

FORMER dockyard worker Jim Ripley, 78, went into the hospital for recuperation from arthritis and bursitis in April 2000 but after a couple of days he started hallucinating.

On the morning of April 8 he became unconscious and despite calls by his wife Paule at 8.30am for a doctor to see him, he was not seen until after 3pm that day. The doctor originally suspected he had suffered a stroke but, after he was transferred to another hospital, he was diagnosed as having suffered an analgesic coma caused by overprescription of morphine, according to Mrs Ripley. She said: "I am extremely angry but very lucky that my husband is alive and so very, very sorry for everyone else that lost their family. My husband had turned from being a strong elderly man to a frightened old man and it was pitiful to see."



The 180-bed Gosport War Memorial Hospital: 50 deaths considered suspicious are being investigated

TIMES ONLINE PRINT THIS ARTICLE

November 07, 2002

Shipman-style inquiry into 50 deaths at hospital

BY MICHAEL HORSNELL AND RUSSELL JENKINS

AN EXPERT in the use of the heroin-based painkiller diamorphine is to be appointed by police conducting an investigation into the deaths of more than 50 elderly patients at a community hospital.

Relations allege that the drug, used by Harold Shipman to kill many of his patients, was overprescribed at the Gosport War Memorial Hospital near Portsmouth.

Detectives are preparing to interview relations of those who died at the 180-bed hospital amid claims of unlawful killing. Many patients died while receiving recuperative care under a regime in which prescriptions for morphine and other potent drugs, it is claimed, were regularly written in advance so that nurses could administer them unsupervised.

Ann Alexander, a solicitor who represented more than 300 families in the Shipman inquiry, had a two-hour meeting with Detective Chief Superintendent Steve Watts, of Hampshire police, and his deputy, Nigel Neven, yesterday.

She said: "It was a very productive meeting. They have completely reassured me about their intentions to do whatever they can to get to the bottom of whatever has been going on at this hospital."

After complaints by relations that police had failed to respond fully to initial concerns, it was disclosed that officers will look at how Greater Manchester Police organised the Shipman inquiry, notably its use of expert witnesses. Ms Alexander said: "The police want to see every single family that wishes to see them. They are hoping that anyone who has not been in touch and who has concerns should come forward."

The meeting, at her office in Altrincham, near Manchester, came after worried families contacted a helpline set up by health managers. A total of 57 people attended a public meeting held by Alexander Harris, a firm of solicitors, on Sunday to hear concerns about treatment at the hospital dating back to the early 1990s.

The firm represents relations of 27 elderly patients who died at the hospital and one who survived, but there are believed to be at least as many again whom detectives want to contact. Among the cases under investigation are those of Leonard Graham, 75, who was recovering from pneumonia. Another, Betty Rogers, 67, was recovering from a chest infection. The patient's daughter was urged to go home, having been told that she was not near death. Fifteen minutes later she received a call to say that her mother had died.

Other deaths under investigation include those of Stanley Carby, 65,

Eva Page, 88, and Dulcie Middleton, 85.

The hospital has already been the subject of an investigation by the Commission for Health Improvement, which criticised its prescribing practices. Althought a commission report said that it could not look at any particular death, it found that doses of up to 200 milligrams a day of morphine were being administered by pumps.

In September, the Government's Chief Medical Officer commissioned a clinical audit. Professor Richard Baker, who worked on the Shipman inquiry, was appointed to examine death rates at the hospital.

In the same month, the chief executives responsible for managing the hospital at the time of the deaths were suspended. Ian Piper, of Fareham and Gosport Primary Care Trust, and Tony Horne, of East Hampshire Primary Care Trust, were moved to other duties. The suspensions were prompted after internal documents from 1991, before the deaths, were found which highlighted concerns about the hospital's prescribing practices.

It has sought to reassure its present patients by appointing a senior nurse from another area to review patient care.

Jane Barton, who was in charge of the day-to-day treatment of some elderly patients at the hospital until July 2000, was referred to the General Medical Council in September.

A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

There is no suggestion that Dr Barton, who has refused to comment, or any of the other people who worked at the hospital, deliberately caused harm.

The Hampshire and Isle of Wight Health Authority said: "It is important to note that, while the (Commission for Health Improvement) investigation had some serious concerns about services in the past, it concluded that policies and procedures are now in place to ensure safe standards of care at the hospital."

Hampshire police acknowledged that a meeting between Mr Watts and Alexander Harris, representing the families of people who died at the Gosport hospital, had taken place.

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A Review of Deaths of Patients

at

Gosport War Memorial Hospital

Final version: October 2003

Contents

Acknowledgements

The staff of the records department of Gosport War Memorial Hospital have provided considerable assistance in identifying and obtaining documents for the review, and I am grateful to them for their assistance. I also thank Code A of National Statistics and Code A of Hospital Episode Statistics, and Code A Code A of the Department of Epidemiology and Public Health, University of Leicester, for advice and for undertaking the analysis of the relationship between numbers of deaths and periods of leave. I also acknowledge the assistance of Code A Code A, research associate, in management of the databases required for the review, and Code A for assistance in preparation of the manuscript.

Code A

Summary

This report presents the findings of an audit of care at Gosport War Memorial Hospital that was commissioned by the Code A. Concerns about the care of patients in Gosport hospital were first raised in 1998, and a police investigation is continuing.

The audit has drawn on documentary evidence that has included:

1. A random sample of 81 clinical records of patients who died in Gosport hospital between 1988 and 2000
2. The counterfoils of medical certificates of the cause of death (MCCDs) retained at Gosport hospital relating to deaths in the hospital 1987-2001
3. The admissions books of Dryad ward at Gosport, 1993-2001
4. Surviving controlled drugs registers at Gosport hospital
5. MCCDs completed by a sample of general practitioners in Gosport.

On the basis of these sources of evidence, I have concluded that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that a small number of these would otherwise have been eventually discharged from hospital alive.

The practice was disclosed in several key findings.

- Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver.
- Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia, and strokes.
- Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later.
- In many records, evidence of a careful assessment before use of opiates was absent, and the stepped approach to management of pain in palliative care had not been followed.

In addition to these findings, two other matters also gave rise to concern. The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths, most commonly fractured hips, had not been reported on MCCDs.

Most patients admitted to Gosport under the care of the Department of Medicine for Elderly People had severe clinical problems, and many had been transferred from acute hospitals after prolonged in-patient stays. Some had been admitted for rehabilitation, but many were believed to be unlikely to improve sufficiently for discharge to a nursing home. Consequently, a relatively high number of deaths among those admitted would have been expected. The types of patients (case mix) admitted to Gosport varied during the period of interest (1988-2000), and it was not possible to identify an adequate source of data about numbers of deaths in similar hospitals that 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 would be unlikely.

In undertaking the audit, I have drawn on documentary evidence only. There has been no opportunity for relatives or staff involved in the care of patients in Gosport to give information or comment on the findings. Code A in particular has not been invited to give a first hand account of care at Gosport or comment on the findings of the review. It is possible, therefore, that my conclusions would be altered in the light of information from Code A or other individuals. However, such information would be more appropriately considered in a different type of inquiry, for example that being undertaken by the police, rather than in the context of an audit.

Recommendations

In view of the findings of the audit, I submit the following recommendations:

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Code A and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.
4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to

suspect that some patients at the end of life do not receive adequate analgesia.

5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

Chapter One: Introduction

This report describes a review of the deaths of older patients at Gosport War Memorial Hospital. The review was commissioned by the Code A because concerns had been raised about the care of some elderly patients who had died in the hospital, and is particularly concerned with the deaths of elderly patients under the care of the Department of Medicine for Elderly People.

Gosport War Memorial Hospital is a 113-bed local hospital situated on the Gosport peninsula. It was part of Portsmouth Health Care NHS Trust from April 1994 until April 2002, when the services at the hospital were transferred to the local primary care trusts (Fareham and Gosport PCT, and East Hampshire PCT). Gosport itself is a relatively isolated community at the end of a peninsula with some areas of high deprivation. It is reported to be under-provided with nursing homes

Concerns about deaths at the hospital were raised in September 1998, when police commenced investigations into an allegation that a patient had been unlawfully killed on Daedalus ward. In March 1999, the Crown Prosecution Service (CPS) decided that there was insufficient evidence to prosecute. In 2001, a further police investigation took place, and again the CPS decided that there was insufficient evidence to proceed. In January 2000 an NHS Independent Review Panel found that whilst drug doses were high, they were appropriate in the circumstances.

A complaint was made to the Code A against Portsmouth Healthcare NHS Trust about the death of a patient who had undergone an operation on a broken hip at another hospital and had been transferred in October 1998 to Gosport War Memorial Hospital 1998. The patient had died of bronchopneumonia in

December 1998, and the complaint was that the patient had received excessive doses of morphine, had not received reasonable medical and nursing care, and had been allowed to become dehydrated. The Code A undertook an investigation, at the conclusion of which he accepted professional advice that medical management had been appropriate and that the patient's nursing needs had been systematically assessed and met. The pain relief was judged to have been appropriate and necessary for the patient's comfort and the commissioner did not uphold the complaint.

In March 2001, 11 families raised further concerns with the police about the care and deaths of relatives in 1998, and four of these deaths were referred for an expert opinion. In August 2001, the police shared their concerns with the Commission for Health Improvement (CHI), and CHI then began an investigation.

The CHI Review (2001-2002)

The terms of reference of the review are shown in Box 1.1., and indicate that the aim of the review was to investigate care since 1998 rather than to undertake an investigation into care at the hospital leading up to the complaint first raised in 1998. During the review, CHI studied documents held by the trust, received views from samples of patients, relatives and friends, conducted a five-day site visit during which 59 staff from all groups involved in the care of elderly patients were interviewed, undertook an independent review of the notes of a sample of patients who had died on three wards (Daedalus, Dryad and Sultan) between August 2001 and January 2002, and interviewed relevant agencies, including those representing patients and relatives. On concluding its review, CHI did commend some features of services at Gosport, including leadership in Portsmouth Healthcare NHS Trust, the

standard of nursing care on Daedalus, Dryad and Sultan wards, and the trust's clinical governance framework. However, CHI also reported several concerns (Box 1.2.).

Box 1.1. Terms of reference of the CHI review (CHI, 2002).

The investigation will look at whether, since 1998, there has been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i) staffing and accountability arrangements, including out of hours

ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management

iii) arrangements for the prescription, administration, review and recording of drugs

iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations

v) arrangements to support patients and their relatives and carers towards the end of the patient's life

vi) supervision and training arrangements in place to enable staff to provide effective care.

In addition, CHI will examine how lessons to improve patient care have been learnt across the trust from patient complaints.

The investigation will also look at the adequacy of the trust's clinical governance arrangements to support inpatient continuing and rehabilitation care for older people.

Box 1.2. CHI's key concerns

- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.
- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the 'Wessex guidelines', this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.
- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non-physical symptoms of pain, the trust's policies do not include methods of non-verbal pain assessment and rely on the patient articulating when they are in pain.
- Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of Code A There were no arrangements in place for the adequate supervision of the Code A working on Daedalus and Dryad wards.
- The police investigation, the review of the Health Care Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

CHI did undertake an independent review of anonymised medical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. It should be noted that this was a period in which the Code A no longer worked at the hospital, and in particular excludes deaths during the period 1998-1999, when concerns first arose. The case note review confirmed that the admission criteria for Dryad and Daedalus wards were being adhered to. CHI also investigated the amount of diamorphine, haloperidol and midazolam used on Daedalus and Dryad wards between 1997/1998 and 2000/01. These data indicated a decline in use of diamorphine and haloperidol on both wards after 1998/1999, with a relatively less marked decline in the use of midazolam in the later years.

Staff concerns about the use of diamorphine, 1991-2

Staffs concern about the use of diamorphine was brought to the attention of the branch convenor of the Royal College of Nursing (RCN) in April 1991, the convenor being told that the problem had been present for the past two years. At a specially convened meeting in July 1991, nursing staff of Redclyffe Annexe raised their concerns about the use of diamorphine with the Code A of Gosport Hospital. Among the points made at that meeting were that not all patients who had been given diamorphine had pain, no other forms of analgesia had been considered, the drug regime was not always tailored to each patient's individual needs, and that deaths were sometimes hastened unnecessarily. Discussions took place between nursing and medical staff, the patient care manager and the RCN convenor over the ensuring months, with the result that a plan for the use of diamorphine appears to have been agreed.

The role of the Code A

The concerns, police investigations and GMC referral have focussed on the role of the Code A involved, Code A is a general practitioner based in a practice in Gosport. She was employed for five sessions a week as a Code A in the Department of Medicine for Elderly People from 1st May 1988 until her resignation on 5th July 2000. In this post, Code A was accountable to the consultant physician in geriatric medicine, and responsible for arranging cover for annual leave and sickness absence with her practice partners. The post was subject to the terms and conditions of hospital, medical and dental staff.

When Code A began work at the hospital, she had responsibility for patients in Redclyffe Annexe. This unit is isolated from the main parts of the hospital, and had

approximately 20 beds classified as continuing care. Until 1993/4, there were also two wards (referred to as the male and female wards) at the main hospital site, having a total of approximately 37 beds (Box 1.3.). Nineteen of these were designated for use by patients under the care of their GP, and seven designated as GP day surgery beds. Code A was responsible for the care of patients in the remaining 11 beds. (The precise number of beds on the female ward is uncertain since the information is based on the memories of staff. It is believed to have been 20 or 21.) The total number of beds under the supervision of Code A was therefore 31 until 1993/4.

From 1993/4, Code A appears to have ceased responsibility for Redclyffe Annexe, and taken on responsibility for Dryad and Daedalus wards in the new hospital building, the male and female wards being closed. This gives a total of 44 beds under Code A 's care, with a mix of continuing care and rehabilitation. CHI was critical of arrangements for supervising the practice of the clinical assistant, and found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Some of the staff interviewed had indicated that the Code A worked in excess of the five contracted sessions. The CHI review notes that in 1998, there was a fortnightly consultant ward round on Daedalus ward. Ward rounds were also scheduled fortnightly on Dryad ward, although they occurred less frequently.

Box 1.3 Reported bed use at the hospital

1980-1993:

Northcott house, 11-12 continuing care beds

Redclyffe Annexe 20 continuing care beds

Male ward - 17 beds (9 continuing care, 8 GP beds)

Female ward – 20 beds (2 continuing care, 7 GP day surgery, 11 GP beds)

Total beds 1980-1993=69

From 1994:

Redclyffe Annexe was still used;

Sultan ward – 24 GP beds

Dryad ward – 20 continuing care beds

Daedalus – 24 beds in total (8 slow stream stroke from April 1994. 16 continuing care [24 prior to April 1994]); from 2000, the Daedalus beds were used for intermediate care, comprising 8 fast stream stroke, 8 slow stream stroke, 8 general rehabilitation.

Other investigations

Several other investigations have been, or are being, undertaken into the events at Gosport War Memorial Hospital. Hampshire Constabulary are continuing an intensive investigation, and I am grateful to them for their agreement that the review requested by the Code A should be completed. A referral to the General Medical Council (GMC) has also been made. However, the review described in this report is an independent clinical review or audit. I have sought to come to an

independent view based on an analysis of clinical information from surviving documentary evidence (for example, clinical records, drug registers, medical certificates of the cause of death, and ward registers). The review does not consider statements from witnesses, and does not involve a detailed forensic inquiry into particular deaths, since these aspects are the proper responsibility of the police and other agencies.

Aims of the review

The aims of the review were:

1) To identify any excess mortality or clusters of deaths among patients who were on Daedalus and Dryad wards 1988-2000 and to identify initial evidence to explain any excess or clusters.

2) To determine whether the numbers of deaths among Code A 's general practice patients was higher than would have been expected.

Palliative and terminal care

Some understanding of current practice and policies on the care of dying patients is required in order to enable judgements to be made about the appropriateness of care given to patients who died in Gosport War Memorial Hospital. This section outlines relevant features of this aspect of care.

The World Health Organisation (WHO) defines palliative care as 'the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families' (O'Neill and Fallon, 1997). Palliative care for people with advanced cancer is now widely available. However, people with other chronic progressive

conditions may also need palliative care when other treatment ceases to be of benefit. Such conditions include advanced respiratory, cardiac or neurological disease (O'Brien et al, 1998). Some of the patients who died on Daedalus and Dryad wards had dementia, and in recent years, it has been increasingly recognised that palliative care also has a role to play in advanced (or 'end stage') dementia. Since a basic awareness of the care of the people with advanced dementia is required in order to interpret the findings of this review, an outline of selected key issues follow.

In advanced dementia, death occurs as a consequence of the many secondary impairments that arise, including progressive immobility, reduced ability for self-care, poor nutrition and reduced intake of fluids, infections related to immobility, skin breakdown, and general debilitation (Shuster, 2000). Although patients dying from dementia have symptoms and health care needs comparable with cancer (McCarthy et al, 1997), patients on long-stay wards who are dying at the end stage of dementia do not always received appropriate palliative care.

In a study undertaken in a long-stay psychogeriatric unit in England, patients with end stage dementia were found to have many symptoms, including pain, dyspnoea and pyrexia for which no palliative treatment was given. Instead, there was widespread use of parenteral antibiotics and infrequent use of analgesia in the last few days of life (Lloyd-Williams 1996). In a follow-up to this study, guidelines on palliative care in end stage dementia were developed, and an increase in the use of analgesics including opiates occurred (Lloyd-Williams and Payne, 2002). The data collected after the implementation of the guidelines related to the deaths of 27 patients, of whom 13 (48%) were prescribed 4-hourly morphine for the palliation of pain or shortness of breath (caused by pneumonia). Two patients who were unable

to take oral medication were commenced on diamorphine administered by syringe drivers. It should be noted that pneumonia can cause significant symptoms in people with dementia, including shortness of breath and discomfort (Steen et al, 2002). Deficiencies in palliative care of elderly patients with or without dementia are also found in other countries (Fox et al, 1999; Evers et al, 2002; Morrison and Siu, 2000).

Information about a palliative care service for elderly people in the same district as Gosport is pertinent to the review. In 1989, a 12-bedded palliative care ward was opened within the Geriatric Department at Queen Alexandra Hospital, Portsmouth (Severs and Wilkins, 1991). The aim was to improve the care of elderly people at the end of life. In the first year, 128 patients were admitted to the ward, of whom 101 (78.9%) had cancer, 17 had strokes and two had dementia. The service was therefore primarily caring for elderly people with terminal cancer.

Guidelines

Communication between professionals (nurses and doctors), and between professionals and relatives or dying elderly patients is sometimes poor (Costello, 2001), and decisions on whether resuscitation would be appropriate ('do not resuscitate' or DNR orders) may not be fully discussed (Costello, 2002). Wider use of clinical guidelines might assist health professionals overcome these problems and provide palliative care to more of those patients who need it. A growing number of publications offer guidance about palliative care for patients with cancer, but the two clinical guidelines discussed here illustrate current professional opinion about the care of people in the terminal phase of dementia. The first guideline was developed in a long-stay hospital in England (Lloyd-Williams and Payne, 2002), and was

concerned with the palliative care of patients with end stage dementia. It is summarised in Box 1.4.

Box 1.4. Guidelines for the management of patients with end stage dementia (from: Lloyd-Williams and Payne, 2002)

Consider treatable causes of pain (e.g. pressure sores, full bladder); use oral medication when possible, and administer on a regular basis; use co-proxamol initially; if still in pain, consider a non-steroidal anti-inflammatory drug.

When opiates are used, start with a low dose and increase as needed to control pain; always prescribe diamorphine 2.5-10mg for injection on an as required basis so that analgesia can still be given if the oral route is not available.

When converting from oral subcutaneous opiates, remember to divide the total oral dose by three e.g. 60mg oral morphine in 24 hours = 20mg diamorphine in syringe driver.

In the event of agitation, think of full bladder; midazolam 2.5mg-10mg subcutaneously or oral haloperidol or thioridazine may be used.

The most common cause of dyspnoea is bronchopneumonia. There is no evidence that using antibiotics in end stage dementia is helpful or improves patients' comfort or prolongs the quality of life. Oral morphine 5mg 4-hourly can reduce the sensation of breathlessness and improve patient's comfort.

The second guideline mentioned here was developed to help physicians decide *whether to forgo curative treatment of pneumonia in patients with dementia resident*

in nursing homes, and has been developed by a research group in the Netherlands (Steen et al, 2000). The guidelines were based on a literature review, discussion papers prepared by Dutch medical associations, and consensus procedures with experienced nursing-home physicians and international experts in the fields of nursing-home medicine, ethics and law. The guidelines were subsequently authorized by the Dutch professional organisation of nursing home physicians. The guidelines were presented in the form of a checklist for use by physicians in nursing homes (see Box 1.5.).

Box 1.5. Checklist on decision for starting or not starting a curative treatment of pneumonia in a patient with dementia (Steen et al, 2000).

The key factors to consider are:

1. the expected effect of a curative treatment from the medical perspective
2. the patient's wish: a living will, or the reconstruction of the wish
3. the patient's best interest when the wish of the patient is not clear, or remains unknown.

The checklist considerations:

1. Is an intentionally curative treatment indicated for this patient?
2. How physically and/or psychiatrically burdensome would the total curative treatment – antibiotics and (re)hydration – be for the patient?
3. Is the patient sufficiently mentally competent to indicate their wish, and if so, what treatment does the patient want?
4. What is the purport of the written will?
5. What is the purport of the reconstruction of the patient's will according to the representative(s)?
6. What is the purport of the reconstructed patient's wishes according to the other involved professional carers?
7. Which treatment seems to be in the patient's best interests (not certain, intentionally curative treatment, or palliative treatment)?

An important step in palliative care is the point at which terminal care begins. The factors that lead to the decision to begin terminal care will depend on the stage of the patient's disease. An example of criteria that may be used for initiating terminal care is shown in Box 1.6 (Edmonds and Rogers, 2003).

Box 1.6. Criteria for starting an integrated care pathway for patients dying in hospital (from Edmonds and Rogers, 2003)

Patients who have a known diagnosis and have deteriorated despite appropriate medical intervention. The multiprofessional team have agreed the patient is dying and at least two of the following apply:

The patient:

1. is bedbound
2. is only able to take sips of fluids
3. has impaired concentration
4. is semi-comatose
5. is no longer able to take tablets

General Medical Council Guidance

In 2002, the general Medical Council (GMC) (GMC, 2002) issued guidance on withholding life-prolonging treatment. Much of this guidance is not directly relevant to an assessment of the care of patients at Gosport, but the guidance does state guiding principles dealing with respect for human life and patients' best interests. These make clear what is expected of doctors in the UK, and are relevant to judgements that may be made about the care of people under the care of the Department of Medicine for Elderly People at Gosport Hospital. The relevant section of the guidance is quoted in full in Box 1.7.

Box 1.7 Respect for Human Life and Best Interests (GMC, 2002)

Doctors have an ethical obligation to show respect for human life; protect the health of their patients; and to make their patients' best interests their first concern. This means offering those treatments where the possible benefits outweigh any burdens or risks associated with the treatment, and avoiding those treatments where there is no benefit to the patient.

Benefits and burdens for the patient are not always limited to purely medical consideration, and doctors should be careful, particularly when dealing with patients who cannot make decisions for themselves, to take account of all the other factors relevant to the circumstances of the particular patient. It may be very difficult to arrive at a view about the preferences of patients, who cannot decide for themselves, and doctors must not simply substitute their own values or those of the people consulted.

Prolonging life will usually be in the best interests of a patient, provided that the treatment is not considered to be excessively burdensome or disproportionate in relation to the expected benefits. Not continuing or not starting a potentially life-prolonging treatment is in the best interests of a patient when it would provide no net benefit to the patient. In cases of acute critical illness where the outcome of treatment is unclear, as for some patients who require intensive care, survival from the acute crisis would be regarded as being in the patient's best interests.

End of natural life

Life has a natural end, and doctors and others caring for a patient need to recognise that the point may come in the progression of a patient's condition where death is drawing near. In these circumstances doctors should not strive to prolong the dying

process with no regard to the patient's wishes, where known, or an up to date assessment of the benefits and burdens of treatment or non-treatment.

Notes on selected drugs

1. *Morphine and diamorphine*

Important sections of the review are concerned with the use of selected drugs towards the end of life. Brief notes about relevant drugs are included here for those who may not be familiar with them. The transition from the weaker to the stronger analgesics is usually described in terms of a three step ladder (Twycross et al, 1998), beginning with non-opioid analgesics such as paracetamol (step one), followed by the addition of a weak opioid such as codeine or dextromoramide (step two), the final step being the addition of a strong opioid.

Morphine and diamorphine are both strong opiate analgesics. Although there is a risk of dependence if the drugs are administered repeatedly, the British National Formulary (2001) makes clear that this should not be taken as a reason for not using regular opiates in terminal care. Morphine is the treatment of choice for oral treatment of severe pain in palliative care, and a dose of 5-10mg given every 4 hours is enough to replace a non-opioid analgesic such as paracetamol or a non-opioid and weak opioid used in combination (for example, paracetamol with dihydrocodeine). However, the dose should be increased stepwise according to response. Oramorph is a pharmaceutical company's name for a particular preparation of oral morphine. Modified release preparations suitable for twice daily administration are available as tablets (for example MST Continus), capsules or in suspension.

If the patient becomes unable to swallow, intramuscular morphine may be given, the equivalent dose being half the dose of the oral solution. However, diamorphine is preferred for injection because it is more soluable and can therefore be given in smaller volumes. The equivalent intramuscular or subcutaneous dose of diamorphine is one third the oral dose of morphine (Twycross et al, 1998). Thus, if a patient has been receiving 10mg of morphine oral solution every 4 hours (a total of 50 mg in each 24 hours), the equivalent dose of diamorphine administered subcutaneously by syringe driver would be approximately 17 mg in 24 hours.

Agitation, confusion and myoclonic jerks occur as a consequence of opiate toxicity. These features may be interpreted as un-controlled pain, leading to the administration of more opiate medication. The consequences are increased sedation, dehydration and further toxicity (O'Neill and Fallon, 1997).

2. *Fentanyl*

Fentanyl (Durogesic) is a strong opioid analgesic that can be absorbed through the skin, and is therefore administered by self-adhesive patches applied to the skin. The patch releases a defined dose per hour over a period of 72 hours, after which the patch should be replaced.

3. *Haloperidol*

Haloperidol is given in syringe drivers to control nausea and vomiting, in doses of 2.5 to 10mg in 24 hours. It is an antipsychotic, but has little sedative effect.

4. *Hyoscine hydrobromide*

Hyoscine hydrobromide is used to control respiratory secretions and is given by syringe driver in doses of 0.6 to 2.4 mg per 24 hours. Drowsiness is a side-effect

5. *Midazolam*

Midazolam (Hypnovel) is a benzodiazepine sedative and is suitable for the very restless patient, in doses of 20 to 100 mg in 24 hours. Drowsiness is a side-effect, and haloperidol is an alternative if symptoms are not controlled by doses of 30mg or less per 24 hours (Twycross et al, 1998)

The Wessex Guidelines

Local guidelines on palliative care were available to health professionals in Gosport. They were published by the Wessex Specialist Palliative Care Unit, and were referred to as the "Wessex Guidelines". The edition of the guidelines current in 1998 recommended assessment of pain, including the site, severity, duration, timing, and aggravating and relieving factors. The use of a body diagram and the patient's own words were recommended as part of the assessment. Depending on the findings of the assessment, analgesics if appropriate were advised, in accordance with the three steps in the WHO analgesic ladder (step one non-opioids, step 2 weak opioids, step 3 strong opioids). The guidelines included advice about the choice of opiate analgesics, and selection of dose, the recommendations being in accordance with the notes and drugs discussed above. The guidelines noted that the use of nebulised opioids was not supports by scientific evidence and might induce bronchospasm. The guidelines address all aspects of clinical management in palliative care, in addition to use of medication.

An Overview of The Report

The review is presented in the following six Chapters. Chapter Two reports an investigation of a random sample of clinical records of patients who died between 1988 and 2000. The review of records was undertaken following review of five records of patients whose deaths were being investigated by the police, and sought to describe clinical practice in the Department of Medicine for Elderly People at Gosport hospital.

In Chapter Three, an analysis of the numbers of deaths in Gosport hospital 1988-2000 is presented, the data being based on counterfoils of medical certificates of the cause of death completed by doctors at the hospital. The data are used to describe the certified causes of death, to identify clusters of deaths, and the features of patients whose deaths had been certified by Code A The Chapter also outlines the difficulties encountered in use of Hospital Episode Statistics to explore patterns of deaths in Gosport hospital.

Chapter Four presents the findings of a review of information obtained from admissions books from Dryad ward. The admissions books contain information about the duration of admission, whether patients had died or were discharged from the ward, the place patients were admitted from, and some indication of the reason for admission.

An investigation of information contained in retained controlled drugs registers is reported in Chapter Five. Data in the registers indicate which patients received opiate medication, how much medication they received, and the wards on which patients were staying. The information was related to information from the

counterfoils of medical certificates of the cause of death to investigate the proportions of people who died who had received an opiate.

Chapter Six presents information obtained from medical certificates of the cause of death completed by Code A and a comparison sample of general practitioners. This analysis was undertaken to determine whether the numbers of deaths among patients in general practice was as expected. Finally, Chapter Seven presents the conclusions and a small number of recommendations.

Ethics approval

Approval for access to data from Hospital Episodes Statistics and National Statistics was obtained from the ethics committees of these organisations. The methods of the audit were discussed with the Code A of the Isle of Wight, Portsmouth and SE Hants Local Research Ethics Committee, and it was confirmed that it was not a research study that required approval. The audit has been undertaken in accordance with the guidance of the GMC on confidentiality. In the Chapters that follow, care has been taken to exclude any material that might lead to the identification of individual patients.

Much of this review is focused on the work of Code A This should not be taken as meaning that Code A was the origin of approach followed at Gosport hospital, or that her clinical practice was the key problem that has given rise to the concerns expressed by relatives. Since Code A issued most of the medical certificates of cause of death for patients of the Department of Medicine for Elderly People, made most of the entries in the clinical records, and was responsible for most of the prescribing, she has served as a means of identifying patients and care that should be included in the review. However, it should be recalled that she was a member of a

clinical team, and the review has not investigated the process of decision making in the clinical team. The audit relied on documentary evidence about care of patients at Gosport, and did not involve consideration of statements from individuals. Therefore, conclusions about the actions of individuals should not be reached since they have not had the opportunity of presenting their own side of the story.

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Chapter Two. Review of records

A review of records of cases reported to Hampshire Constabulary

In 1998, the initial police investigation into care of patients at Gosport War Memorial Hospital was prompted by the death of one patient that was reported to the police by the family of the deceased as a potential case of unlawful killing. In the months that followed, other families who had become aware of concerns about care at the hospital also contacted the police. From the cases notified to them, the police had, by December 2002, identified five cases that shared certain features that indicated the need for detailed investigation. The police permitted me to review the clinical records of these cases.

The aim of the review of these records was to identify those features recorded in the records that might give rise to concern about the care patients had received and the cause of death. The police had invited a small number of clinical experts to review the records, but I did not consult the reports of these experts in order to ensure that an independent opinion was reached. The records available included all those made by medical and nursing staff at Gosport War Memorial Hospital, drug charts, X rays and investigation reports, records made by staff in acute hospitals in the case of those patients who had been transferred to Gosport from another hospital, and correspondence from patients' general practitioners. The features identified from the five sets of records were:

1. *All were frail, with major clinical problems.* All five had been admitted to Gosport War Memorial Hospital from other services, for example from acute hospital following surgery for a fractured hip, or from a day hospital. All were

dependent on nursing care and had more than one health condition, including for example Alzheimer's disease, Parkinson's disease, or cancer. Their continuing problems included pressure sores, mobility, confusion and incontinence.

2. *In some cases, active treatment had been planned.* Some, although not all of the five patients had been admitted to Gosport to enable active treatment to be arranged, for example rehabilitation after a fractured hip, or aggressive treatment to heal a sacral ulcer. It should be noted, however, that in one case admission was for palliative care, and in another the prognosis had been noted as poor prior to transfer from an acute hospital.
3. *Oramorph was written on the drug chart on admission.* In four of the five cases, Oramorph was prescribed although not necessarily administered on the day of admission.
4. *Diamorphine was administered by syringe driver in all cases.* Diamorphine was commenced when a patient had pain not otherwise controlled, was noted to be agitated, or had deteriorated in some way. Diamorphine was usually administered with hyoscine and midazolam.
5. *Doses of opiates were unexceptional.* Patients were not given extremely high doses of diamorphine or Oramorph, although it should be noted that they were all frail and elderly, and diamorphine was administered along with midazolam.
6. *The records did not contain full explanations for the treatment decisions.* The medical records were generally rather brief, although the amount of detail varied between doctors. Consultants tended to make more detailed notes. The reason for selecting morphine rather than a non-opiate analgesic was not recorded, even though in some cases other analgesics had not been used. Likewise, the decision to initiate subcutaneous diamorphine by syringe

driver or the reasons for not investigating the potential causes of new symptoms such as pain or agitation were often not fully described.

7. *Remarks in the records suggested a conservative rather than active attitude towards clinical management.* Two of the five records included the instruction by a doctor to nursing staff: 'Please make comfortable'; three records included: 'I am happy for nursing staff to confirm death', written by Code A in all cases on the day of admission.

Review of a random sample of records

Having identified features of cases that the police had been investigating, a review of a random sample of records of patients who had died in Gosport War Memorial Hospital was undertaken. The aims of the review were to (a) determine whether other cases shared these features, and (b) describe the pattern of care of patients who died in the hospital. The review concentrated on patients who had been under the care of Code A, since the medical certificates of cause of death (MCCD) of most patients who had died on Daedalus and Dryad wards had been issued by Code A Code A Most MCCDs issued by Code A would have been for patients who have been under the care of the Department of Medicine for Elderly People.

Method

Patients whose deaths had been certified by Code A between 1987 and 2002 were identified by National Statistics. From 1993 onwards, information about deaths has been stored on a computer system by National Statistics, and those certified by Code A Code A were readily identified. However, prior to 1993 information was stored on paper only, and a hand search of files containing information about deaths notified in districts local to Gosport was required. The information held on computer or paper

systems consists of details recorded by the certifying doctor on the MCCD, and associated information provided to the registrar of births, marriages and deaths by the informant, who is usually a relative of the deceased. In this report, the summaries of the information from these two sources combined are referred to as death notifications. In addition to the name of the deceased, date of death, and certified cause of death, the information available includes the name of the doctor who issued the MCCD, and the place of death.

The sample of records selected for review was taken from the notifications provided by National Statistics. The review sampled cases from 1988 until 2000, from the beginning of Code A 's work at the hospital until she left her post of Code A Code A A 10% sample of the 833 deaths certified by Code A during this period was selected using the random sampling procedure in the Statistical Package for the Social Sciences (SPSS), the principal statistics software employed in this review.

The hospital records of all deceased patients had been retained by Portsmouth Healthcare NHS Trust for all years during which Code A worked at Gosport, although records of patients who died in 1995 or before had been stored on microfiche. The record department of Gosport War Memorial Hospital was asked to provide all the sampled records, and once these had been retrieved, the review was undertaken. The information extracted from each record is shown in Table 2.1. The notes recorded by both doctors and nurses were reviewed, and drug charts were also inspected. In addition, in each case my own observations on the patient's care were recorded, and the cause of death as certified by Code A was noted. Causes of death were grouped into six categories, according to the first cause of death noted on the MCCD. Thus, the category 'cancer' included all deaths in which a type of cancer was given as the first cause of death. Heart conditions included myocardial

infarction, heart failure, ischaemic heart disease, and other heart disorders. Stroke included both cerebral thrombosis and cerebral haemorrhage. Some certificates gave bronchopneumonia as the sole cause of death, and these were placed in a category distinct from deaths certified as due to bronchopneumonia associated with other conditions that included cancer, dementia, or other disorders. The 'other' category included dementia, old age, renal disease, progressive neurological conditions and other medical conditions not included in the five other categories.

Table 2.1. Information extracted from the clinical records

	Information collected from records
1	Age and gender
2	Date of admission
3	Past medical history
4	History of the final illness
5	Administration of opiate medication

Results

The sample consisted of 85 patients. The records of four were held by the police and therefore were excluded from this review. All the remaining 81 records were reviewed. The numbers of records in each year are shown in Table 2.2. The mean age of patients in the sample was 84.5 years (95% confidence interval 82.8-86.1), and in the group not sampled 82.7 years (95% confidence interval 82.2-83.3). The proportion of females was slightly higher in the sample than in the group not in the sample (Table 2.3), although this did not reach statistical significance (Chi Sq 3.26, df 1, p 0.07). There was no difference between the groups of patients included in and excluded from the sample with respect to the numbers of patients certified as dying from different categories of illness (Chi Sq 3.02, df 5, p 0.70) (Table 2.4).

Table 2.2. Numbers of deaths in Gosport War Memorial Hospital certified by Code A in total, and numbers in sample, 1988-2000.

Year	Number of patients in sample	Number of deaths certified by Dr Barton
1988	2	19
1989	4	30
1990	3	38
1991	6	31
1992	2	32
1993	10	94
1994	8	104
1995	7	80
1996	8	84
1997	11	86
1998	7	107
1999	12	92
2000	1	34
Total	81	833

Table 2.3. Numbers (%) of males and females in the sample compared to those not in the sample the (the Table does not include the four cases excluded from the sample).

Gender	Not in sample	In sample	Total
male	337 (45.1)	28 (34.6)	365 (44.0)
female	411 (54.9)	53 (65.4)	464 (56.0)
total	748	81	829

Table 2.4. Numbers (%) of deaths due to different categories of disease, in those patients included in and excluded from the sample.

Category of disease	Not in sample	In sample	Total
Cancer	44 (5.9)	5 (6.2)	49 (5.9)
Heart	85 (11.4)	7 (8.6)	92 (11.1)
Stroke	122 (16.3)	13 (16.0)	135 (16.3)
bronchopneumonia + other conditions	331 (44.3)	33 (40.7)	364 (43.9)
bronchopneumonia only	139 (18.6)	21 (25.9)	160 (19.3)
Other	27 (3.6)	2 (2.5)	29 (3.5)
total	748	81	829

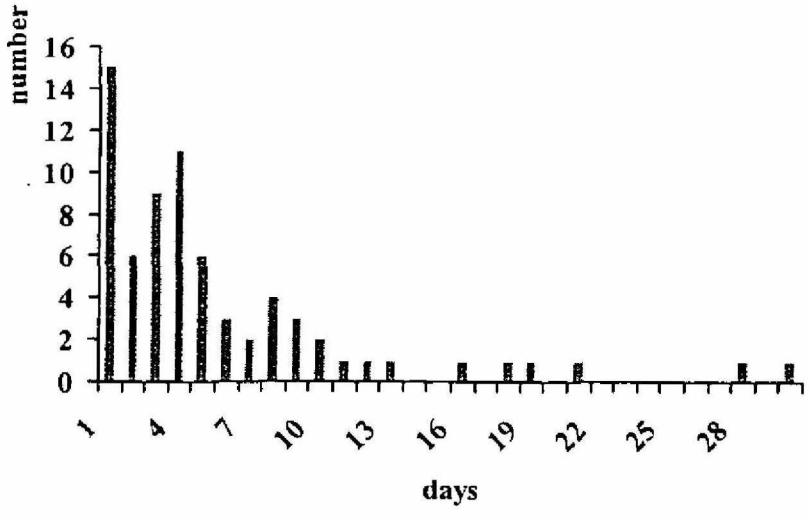
The patients in the sample were almost all elderly; all except two were aged 70 or over (one was aged 69 and one 60). Twenty-one (25.9%) were aged 90 or above (one was aged 100). Typically, patients had been transferred to Gosport following admission to an acute hospital for a major illness, the transfer to Gosport being arranged because the patient would have required more support than could have been provided in a nursing home. In some cases, the aim of transfer to Gosport was rehabilitation, for example, following a stroke or fractured hip. In others, the aim was long term care, as in patients with lasting disabilities following major strokes, or with terminal cancer. Many patients also had other comorbid conditions contributing to the development of dependence on nursing care, including advanced dementia and cardiovascular disease.

Table 2.5. Numbers (%) of patients who received opiate medication before death

	N	%
None	5	6.2
Diamorphine only	21	25.9
Oramorph and diamorphine	38	46.9
Other oral opiates and diamorphine	13	16.0
Other opiates, no diamorphine	4	4.9
Total	81	100.0

Most patients had received an opiate before death (Table 2.5). The most common pattern was initial use of Oramorph, followed by diamorphine subcutaneously. When used in a syringe driver in this way, diamorphine was invariably accompanied by other drugs. In 1988, diamorphine was used in combination with atropine, but in subsequent years it was combined with hyoscine and midazolam. In one case, the duration of opiate medication could not be determined from the records. The other 76 who received opiates were administered the drugs for a median of four days (range 1 – 120 days, inter-quartile range 7 days) (see Figure 2.1).

Figure 2.1. Duration of administration of opiate medication (chart excludes 2 patients at 42 days, 3 at 90 days and 1 at 120 days).



The pattern of use of opiates in these patients generally involved the administration of an oral opiate for pain or distress from whatever cause, followed by the use of subcutaneous diamorphine when the patient became unable to swallow oral medication. This process was usually triggered by a deterioration in health. An example taken from the medical records is as follows:

'further deterioration. Uncomfortable coughing, to have a tiny dose of oramorph regularly Code A are Code A s initials) (Case 1210).

Oramorph would also be commenced by other doctors, for example:

Oedema worse, relative feels patient has had enough. Oramorph started. (Signature not clear) (Case 1209).

If the patient deteriorated further, subcutaneous diamorphine would be used, for example:

'Further deterioration in general condition. In pain, confused and frightened. sc analgesia commenced. Code A (Case 1139).

or:

'patient has deteriorated over weekend, pain relief is a problem. I suggest starts sc analgesia and please make comfortable. I am happy for nursing staff to confirm death. Code A (Case 708).

The initial dose of diamorphine varied from 5 mg to 80 mg in 24 hours, doses below 20 mg being administered intramuscularly, and doses of 20 mg or more being administered subcutaneously by syringe driver. Of the 60 patients in whom the starting dose of diamorphine could be established, the most common dose was 40mg (50.8%), followed by 20 mg (31.7%) (Table 2.6). Of the 19 who received 20 mg diamorphine in 24 hrs, the dose of oral morphine being administered before

diamorphine was commenced could be identified in seven. The mean total daily dose of oral morphine in these cases was 27.1 mg. Of the 31 who received a starting dose of diamorphine of 40 mg in 24 hours, the daily dose of oral morphine before changing to subcutaneous diamorphine could also be established in seven cases, and the mean morphine dose in these was 44.3 mg. It is generally recommended that to obtain an equivalent level of pain relief, the dose of diamorphine on transfer from oral morphine should be one third of the total daily oral dose (see Chapter One). If this guidance is followed, a starting dose of subcutaneous diamorphine of 20 mg would equate to a daily dose of oral morphine of 60 mg, and a 40 mg dose of diamorphine would equate to a 120 mg dose of oral morphine in 24 hours.

Table 2. 6. Numbers (%) of patients receiving different starting doses of diamorphine

Diamorphine (mg)	N	%
5	1	1.7
10	2	3.3
15	1	1.7
20	19	31.7
30	2	3.3
40	31	50.8
60	1	1.7
80	3	5.0
Total	60	

The use of opiates was not confined to patients with cancer. Only two (15.4%) patients who were certified as having died from strokes did not receive an opiate, and only three (9.1%) of those who were certified as dying from bronchopneumonia associated with other conditions did not receive an opiate (Table 2.7).

Table 2.7. The certified causes of deaths of patients and the numbers (%) who received an opiate.

	Opiates					Total
	none	*diamorphine only*	*oramorph then diamorphine*	*other opiates then diamorphine*	*other opiates*	
cancer	0	1 (20.0)	3 (60.0)	0	1 (20.0)	5
heart	0	2 (28.6)	2 (28.6)	2 (28.6)	1 14.3)	7
stroke	2 (15.4)	3 (23.1)	8 (61.5)	0	0	13
bronchopneumonia with other conditions	3 (9.1)	10 (30.3)	15 (45.5)	5 (15.2)	0	33
bronchopneumonia alone	0	5 (23.8)	9 (42.9)	5 (23.8)	2 (9.5)	21
other conditions	0	0	1 (50.0)	1 (50.0)		2
Total	5 (6.2)	21 (25.9)	38 (46.9)	13 (16.0)	4 (4.9)	81

Typically, a deterioration in a patient's condition would not be investigated in depth. In many cases this would have been appropriate, since the advanced state of illness and impossibility of further curative or rehabilitative treatment had been well established. However, in some cases, the resort to opiate medication might have been, but was not, preceded by some investigation, or trial of analgesics other than opiates. The degree of assessment of pain recommended in the 'Wessex guidelines' was not usually evident in the records, and body maps to highlight areas of pain were not used. For example:

– *'frightened agitated appears in pain suggest transdermal analgesia despite no obvious clinical justification!!* Code A *to countersign. I am happy for nursing staff to confirm death.* Code A (Case 785).

In 18 (22.2%) cases the drug chart could not be reviewed because a copy had not been stored on microfiche. Nonetheless, in these cases it was possible to describe the use of opiate medication from entries in the medical and nursing records. Drug charts were almost always completed by Code A It was notable that in many cases, prescriptions for opiate medication had been entered by Code A on drug charts on the day of the patient's admission, although the medication was not administered until some days or even weeks later. For example, in the case of a patient who had abdominal obstruction and had been admitted to Gosport from an acute hospital, diamorphine was entered onto the drug chart on the day of admission, but not administered until 16 days later (Case 597). Prescriptions for diamorphine typically indicated a range of dose, to enable adjustment without a new prescription being written. In the example just mentioned, the indicated dose was 20-80 milligrams subcutaneously in 24 hours, to be administered with hyoscine and midazolam. It was not unusual for entries in the records by Code A on the day of admission to include the statement '*I am happy for nursing staff to confirm death* Code A (e.g. Case 530).

The proportion of patients who received an opiate before death did not vary significantly from year to year (Table 2.8). Of the nine deaths that occurred between 1988 and 1990, seven had received an opiate, and it therefore appears that the almost routine use of opiates before death had been established at Gosport hospital long before the initial complaint in 1998.

Table 2.8. Numbers (%) of patients who received an opiate before death, 1988-2000 (Chi Sq 50.0, p not significant).

year	Opiates					Total
	none	*diamorphine*	*oramorph plus diamorphine*	*other plus diamorphine*	*other only*	
1988	1 (50.0)			1 (50.0)		2
1989	1 (25.0)	3 (75.0)				4
1990		2 (66.7)		1 (33.3)		3
1991	1 (20.0)	1 (20.0)	1 (20.0)	2 (40.0)		5
1992			1 (50.0)	1 (50.0)		2
1993		4 (36.4)	3 (27.3)	3 (27.3)	1 (9.1)	11
1994	1 (12.5)	3 (37.5)	4 (50.0)			8
1995		2 (28.6)	5 (71.4)			7
1996		1 (12.5)	6 (75.0)		1 (12.5)	8
1997	1 (9.1)	2 (18.2)	6 (54.5)	2 (18.2)		11
1998		1 (14.3)	3 (42.9)	2 (28.6)	1 (14.3)	7
1999		2 (16.7)	8 (66.7)	1 (8.3)	1 (8.3)	12
2000			1 (100.0)			1
	5 (6.2)	21 (25.9)	38 (46.9)	13 (16.0)	4 (4.9)	81

The medical records were often limited. In 32 (39.5%) of the cases reviewed, the records were judged to be too brief to enable an adequate assessment of care to be made. In particular, they did not always contain information about the decision to initiate opiate medication.

In the review, it was possible to relate information contained in the records to the information reported on death certificates. In 42 (51.9%) cases, the information on certificates was judged to be an incomplete statement of factors contributing to

death. In 16 of these, a recent fracture that had contributed to the patient's condition had not been reported on the death certificate. These included patients who had suffered a fractured hip and undergone operative fixation or partial hip replacement in an acute hospital prior to transfer to Gosport. Indeed, a fracture had not been mentioned on any of the death certificates in the sample. Typically, death in these cases was reported as being caused by bronchopneumonia.

Forty-eight records contained sufficient details to enable a judgement to be made about the appropriateness of care. In 32 (66.7%) of these, care was judged to have been appropriate. There were some concerns about the decision to start opiate medication in the remaining 16 (33.3%). The indications for starting the drugs were either not clearly stated, or if pain was mentioned it had not been investigated, and neither remedial treatment or alternative analgesia had been attempted. For example, the following was written in one set of records in Code A 's handwriting: *'marked deterioration over last 24 hrs. Persistent cough relieved by nebulised diamorphine in N/saline. .... Sc analgesia is now appropriate + neb if required'* (Case 587). No investigation of the cough was described nor treatment other than nebulised diamorphine.

Discussion

A number of qualifications about the review of records should be acknowledged. The information was obtained from the records only, and because of the pressure of routine care in a hospital ward, clinicians may often fail to record extensive details about patient care. In some cases, the drug charts that recorded prescribing and administration of opiate medication were not available because they had not been copied onto microfiche. More complete records, or information obtained through interviews of clinical staff or relatives, might have explained some of the findings

that, on the evidence of the records alone, gave rise to some concern. The sample included only patients whose deaths had been certified by Code A However, the records contained entries from other doctors, and demonstrated that they had made some treatment decisions.

The record review was undertaken to identify broad patterns of care, and therefore included a relatively large number of cases, albeit a sample from over 800 cases. An intensive, prolonged and in depth review of a small number of cases might have reached, in those cases, different conclusions. Nevertheless, despite these reservations, the review does raise questions about the care provided to patients at Gosport War Memorial Hospital.

Features of care

The first aim of the review was to determine whether features associated with the care of patients whose deaths were being investigated by the police could also be found in the sample.

1. All patients were severely ill, having major disabling, or progressive conditions, or illnesses that were unlikely to substantially improve. They were heavily dependent on nursing care, and many had been intensively investigated and treated in acute hospitals before transfer to Gosport.
2. The precise reasons for admission were not always clear from the records, but some patients had certainly been admitted for rehabilitation. The majority of patients, however, had major clinical problems.
3. 93.8% of patients received an opiate, and almost half received Oramorph (Table 2.5). Opiate medication was frequently prescribed on the day of admission, although there was no immediate indication for their use, and they

were sometimes not administered until after several days or weeks. There was little evidence of use of weak or moderate analgesics before resort to oral morphine, opiate medication being used when patients suffered a deterioration in their condition. Further investigation or active treatment were often not undertaken, and alternative analgesics were generally not used first. If pain was a feature of a patient's deterioration, a detailed assessment of the reasons for pain was not usually recorded.

4. Diamorphine was administered to 72 (88.9%) patients, almost always by syringe driver and accompanied with other drugs with sedative properties, most commonly midazolam and hyoscine. Diamorphine was used in all categories of condition (Table 2.7). In those patients in whom the dose of oral morphine could be established, the starting dose of diamorphine tended to be higher than would have been expected. The two potential explanations are that oral opiates were not being administered at sufficient doses to control pain, or that the doses of diamorphine were greater than required.
5. In most cases, opiates were not used for prolonged periods, 47 (61.8%) patients dying within five days of starting treatment.
6. The records were generally brief. On occasions, details were either not recorded, or no entries were made when the patient had been assessed by a doctor, although the consultation was mentioned in the nursing records. The reasons for starting opiate medication were often not adequately recorded, and in 39.5% of cases it was not possible to assess the appropriateness of care.
7. The conservative attitude to treatment identified in the records of the cases being investigated by the police was also evident in the records of the sample. The quotations included above serve to illustrate this finding. The

initial medical assessment of a patient on admission was often concluded with the phrase 'Please make comfortable'.

8. In the case of patients whose deaths had been preceded by a bone fracture (most commonly the hip), Code A did not note the fracture on the medical certificate of cause of death. The Office of National Statistics (ONS) encourages the practice of voluntary referral to the coroner by the certifying doctor of deaths due to accidents (whenever the accident occurred) (Devis and Rooney, 1999). It is conceivable that the local coroner would have undertaken at least some investigation into a number of the deaths that had followed fractures.

The pattern of care

The review included records of patients who died from 1988 to 2000. The findings reveal a distinct pattern dating from 1988. Indeed, the almost routine use of opiates before death appears to date from at least as early 1988, but it is conceivable that this practice was in use before this, and before Code A was appointed as Code A Code A

The patients admitted to Gosport War Memorial Hospital under the care of the Department of Medicine for Elderly People were old and frail. They had major illnesses and were heavily dependent on nursing care. In managing these patients, the culture at Gosport throughout the period appeared, from the records, to have been conservative with regard to treatment and modest with regard to expectations of improving patient health. It may be summed up in Code A s own words, frequently written in the records: 'Please make comfortable'. This approach may have been entirely correct for many of the severely ill and dependent patients

admitted to Gosport. However, it is possible that in some patients, a more active clinical approach would have extended life.

Opiates were used extensively, and often without recourse to other analgesics, detailed assessment of the cause of pain, agitation or deterioration, or active treatment. The doses of diamorphine appear to have been higher than prior doses of oral morphine would have suggested were required, and most patients died within a few days of starting opiates. These observations might be interpreted as indicating that management of patients with terminal illnesses, in placing so much emphasis on the comfort of the patient, were in advance of those followed elsewhere in the health service. However, they might also be interpreted as indicative of a conservative approach to treatment, and even a premature resort to opiates that in some cases may have shortened life.

The lack of detail recorded in the notes about medical decisions, and contrast between the detailed notes written by the consultants and the short entries of other doctors – sometimes written within a few hours of each other – suggests that the level of supervision and teamwork was poor. The failure of the records to provide a coherent description of a patient's illness and care, the often disjointed nature of entries by different doctors, and the lack of detail about some decisions may have been a consequence of inadequate discussion between members of the clinical team on patient management.

The completion of medical certificates of cause of death was inadequate. In particular, the pattern of not reporting recent fractures was not appropriate.

References

Devis T, Rooney C (1999). Death certification and the epidemiologist. *Health Statistics Quarterly*, Spring, 21-33.

Chapter Three: Deaths at Gosport War Memorial Hospital, 1987-2000: A review of Medical Certificates of Cause of Death (MCCDs) counterfoils

Introduction

Medical certificates of cause of death are supplied in books, each book containing 50 certificates. Each certificate is attached to a counterfoil from which it is detached when it is issued. At Gosport, only one book of MCCDs was in use at any one time, the book being held in an office close to the mortuary. It was hospital policy that MCCDs should be issued from the centrally held book, and the books of counterfoils have been retained for a number of years. Consequently, the counterfoils are likely to represent a reasonably complete record of deaths for which an MCCD was issued, although deaths that were referred to the coroner would have been excluded. This chapter describes the findings from review of these counterfoils.

The counterfoils record selected information that is also entered on the MCCD itself, including the deceased's name, date of death, the place of death, and the cause of death. From early 1988, the counterfoils of the books of certificates in use at Gosport also required the certifying doctor to state the deceased's age.

Method

Information from all the available counterfoils was entered into a database. The specific data items are shown in Table 3.1.

Table 3.1. Information obtained from the MCCD counterfoils.

1	Name
2	Gender
3	Age
4	Date of death
5	Certified cause(s) of death
6	Doctor completing the certificate
7	Place of death

The counterfoils were completed in the certifying doctors handwriting. Code A had a distinctive signature almost invariably written with black ink. Consequently, deaths she had certified could be readily and confidently identified. However, the signatures of the other doctors were generally less distinctive, and consequently it was not possible to reliably identify other doctors. The other doctors would have included general practitioners who had cared for patients admitted to general practitioner beds, and doctors attending patients of the Department of Medicine for Elderly People when Code A was not on duty.

Results

1. Numbers of deaths

The numbers of certificates issued each year by Code A and other doctors are shown in Table 3.2.

Table 3.2. Numbers (%) of MCCD counterfoils each year, 1987-2000, completed by Code A or other doctors at Gosport.

Year	Other docs	Code A	Total
1987	105 (98.1)	2 (1.9)	107
1988	85 (74.6)	29 (25.4)	114
1989	71 (69.6)	31 (30.4)	102
1990	72 (65.5)	38 (34.5)	110
1991	59 (65.6)	31 (34.4)	90
1992	68 (68.0)	32 (32.0)	100
1993	57 (36.5)	99 (63.5)	156
1994	56 (34.6)	106 (65.4)	162
1995	74 (47.7)	81 (52.3)	155
1996	100 (54.3)	84 (45.7)	184
1997	106 (55.2)	86 (44.8)	192
1998	107 (50.0)	107 (50.0)	214
1999	71 (43.6)	92 (56.4)	163
2000	81 (70.4)	34 (29.6)	115
2001	103 (98.1)	2 (1.9)	105
Total	1214 (58.7)	854 (41.3)	2069

Between 1987 and 2001, Code A completed 854 MCCDs, 41.3% of all those issued at the hospital. The numbers issued by Code A rose from 1988, when she issued 25% of all those issued in the year, to 1994 when she issued 64% of the total. There was a rise in the total numbers coincident with the rise in proportion issued by Code A, and it was not until 2000 when the total number returned to the levels typical of the years 1987-1992. Code A issued two MCCDs in 2001 for patients

who had died in general practitioner beds, the year after the termination of her clinical assistant post.

2. Age and gender of deceased patients

The mean age of Code A 's deceased patients was 82.8 years, but for the other doctors the mean was 78.8 (t 9.31, df 1807, p<0.001). The difference in age is probably explained by the admission criteria for the different hospital wards. The gender of the deceased could be identified in 2033 (98.3%) of the 2069 cases, and among Code A 's patients 478 (56.8%) were female, in comparison with 623 (52.3%) among the other doctors (Chi Square 3.95, df 1, p 0.047).

3. Certified cause of death

The cause of death, grouped into the six categories as defined in Chapter Two, given by Code A and other doctors are shown in Table 3.3.

Table 3.3: Numbers (%) of deaths certified as due to groups of conditions by Code A and the other doctors (Chi Sq 507.9, df 5, p <0.001).

	Other docs	Code A	
cancer	424 (38.6)	49 (5.8)	473
heart conditions	165 (15.0)	100 (11.8)	265
stroke	106 (9.7)	139 (16.4)	245
bronchopneumonia + other conditions	235 (21.4)	367 (43.3)	602
bronchopneumonia alone	21 (1.9)	162 (19.1)	183
other condition	147 (13.4)	31 (3.7)	178
total	1098	848	1946

Code A s patients were less likely to have been certified as dying primarily because of cancer or heart conditions, but more likely to have died from bronchopneumonia with or without other conditions, or from strokes. Case mix will explain at least some of these differences. Thus, local general practitioners appear to have admitted patients with cancer to Gosport Hospital for terminal care, but Code A Code A was responsible for the care of other groups, including people with Alzheimer's disease or other forms of dementia, and those recovering from strokes or in need of rehabilitation for other reasons.

4. Deceased seen after death, and post-mortems

Code A was more likely to have reported personally seeing the deceased after death (98.6% vs 86.9%, Chi Sq 89.3, df 2, p<0.001). Code A reported that in 99.4% of deaths, no post mortem or referral to the coroner occurred; the proportion for the other doctors was 98.4%. These cases will not have included all cases reported to the coroner, since no MCCD would have been issued by the doctor in those cases that the coroner chose to investigate. In such cases, a certificate would be issued by the coroner at the conclusion of the coronial investigation. Therefore, the deaths indicated as referred to the coroner on the counterfoils are likely to include only those in which a discussion took place with the coroner or coroner's officer, and that concluded that an MCCD should be issued by the doctor.

5. Day, calendar quarter and week of death

The date of death was used to identify the day of week of death. In the case of both Code A 's patients and the patients whose deaths were certified by other doctors, the pattern was as expected, with approximately equal proportions of deaths occurring on each day of the week (Table 3. 4). A marginally greater proportion of Code A Code A s patients died during the winter (October to March), a factor that might be explained by seasonal factors influencing the types of conditions with which patients

were admitted, or because Code A was more likely to take vacations between April and September (Table 3.5). Table 3.6 shows the distribution of deaths during the year when the certified cause of death was given as bronchopneumonia only. Code A Code A issued a greater number of certificates giving this cause of death, although the temporal distribution was no different to that of the other doctors.

Table 3.4. Numbers (%) of patients certified as dying on each day of the week (Chi Sq 5.1, df 6, not significant).

	doctor		total
	other doctors	Code A	
1	174 (15.7)	113 (13.3)	287
2	147 (13.2)	111 (13.0)	258
3	154 (13.9)	122 (14.3)	276
4	151 (13.6)	137 (16.1)	288
5	139 (12.5)	117 (13.7)	256
6	176 (15.9)	132 (15.5)	308
7	169 (15.2)	119 (14.0)	288
	1110	851	1961

Table 3.5. Numbers (%) of patients certified as dying in each calendar quarter (Chi Sq 11.2, df 3, p < 0.01)

quarter	doctor		total
	Other doctors	Code A	
Jan-Mar	269 (24.1)	235 (27.6)	504
Apr-Jun	288 (25.8)	199 (23.4)	487
Jul-Sep	294 (26.3)	182 (21.4)	476
Oct-Dec	266 (23.8)	236 (27.7)	502
	1117	852	1969

Table 3.6. Numbers (%) of deaths in different quarters certified as due to bronchopneumonia alone (Chi Sq 0.67, df 3, not significant).

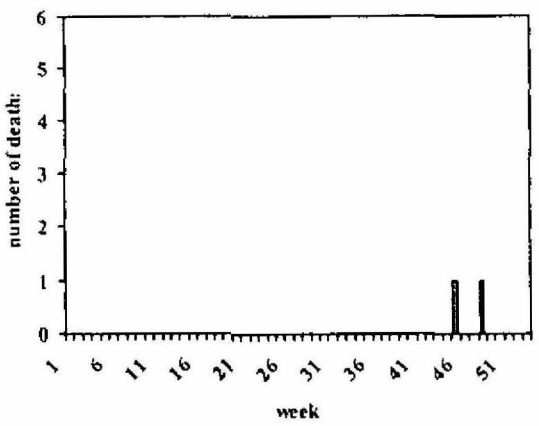
quarter	Doctor		total
	other doctors	Code A	
Jan-Mar	7 (31.8)	51 (31.5)	58
Apr-Jun	6 (27.3)	33 (20.4)	39
Jul-Sep	3 (13.6)	28 (17.3)	31
Oct-Dec	6 (27.3)	50 (30.9)	56
	22	162	184

The distribution of deaths according to week of the year may also be used to identify clusters of deaths, and variations in the numbers of deaths at different times. Table 3.7 shows the mean number of deaths per week certified by Code A from 1988 until July 2000, when she ceased employment at Gosport hospital. The findings demonstrate the increase in the numbers of deaths from 1993, the year in which Dryad and Daedalus wards were opened.

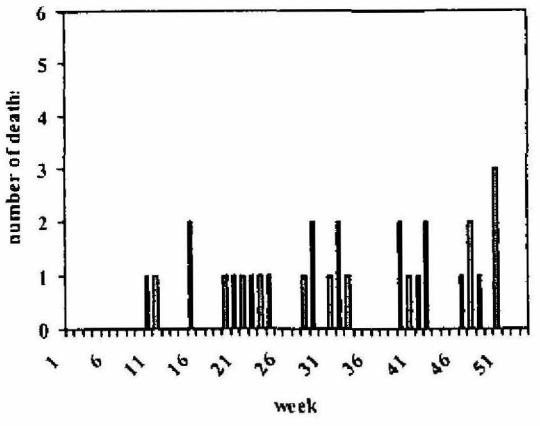
Table 3.7. Mean and standard deviation (SD) of numbers of deaths certified by Code A per week, 1988- 2000.

year	minimum	maximum	number	mean	SD
1988	0	3	29	.53	.77
1989	0	2	31	.58	.69
1990	0	5	38	.72	.97
1991	0	3	31	.58	.89
1992	0	2	32	.60	.77
1993	0	5	99	1.87	1.43
1994	0	6	105	1.98	1.63
1995	0	6	81	1.53	1.31
1996	0	5	84	1.58	1.18
1997	0	6	86	1.62	1.40
1998	0	6	107	2.02	1.57
1999	0	6	92	1.74	1.32
2000	0	4	34	1.31	1.19

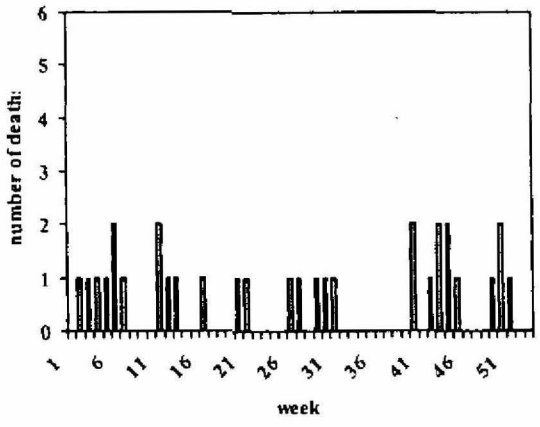
The Figures 3.1 to 3.15 in the following pages show the numbers of deaths certified each week from 1987 to 2001. They demonstrate the rise in the numbers of deaths from 1993 onwards, and suggest a decline in numbers may have occurred during 2000, although Code A worked only until July in that year. The two deaths in 1987 would presumably have been for patients in general practitioner beds under the care of Code A or one of her partners in her general practice. Other than the rise in numbers of deaths from 1993, the Figures do not indicate any clear clusters of deaths or patterns of concern.



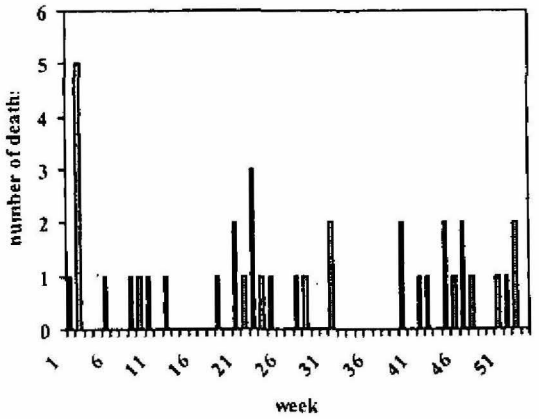
3.1. Deaths in 1987



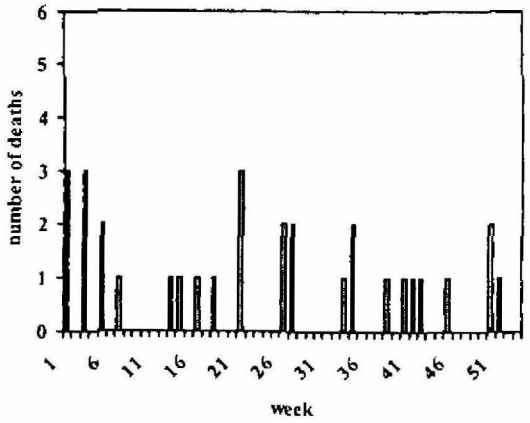
3.2. Deaths in 1988



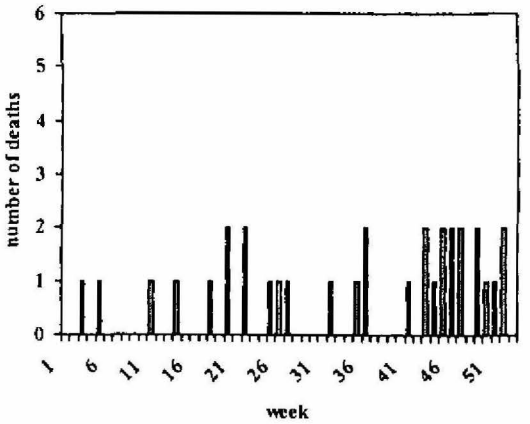
3.3. Deaths in 1989



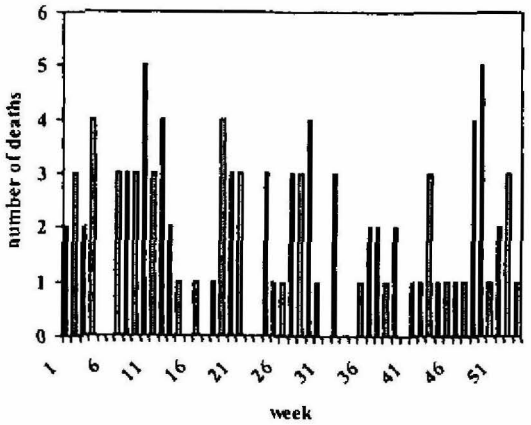
3.4. Deaths in 1990



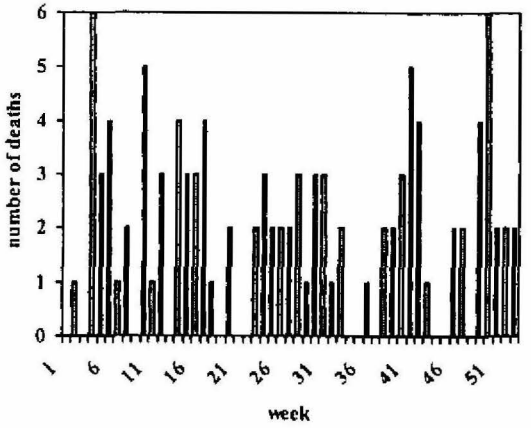
3.5. Deaths in 1991



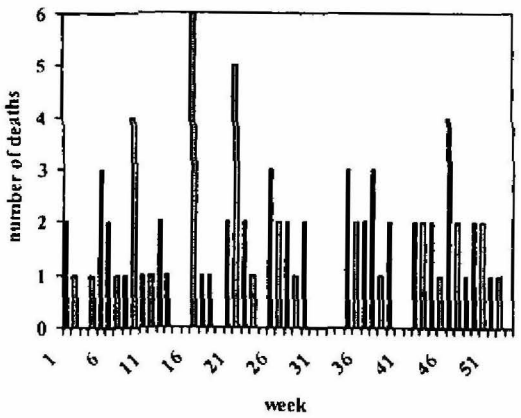
3.6. Deaths in 1992



3.7. Deaths in 1993



3.8. Deaths in 1994



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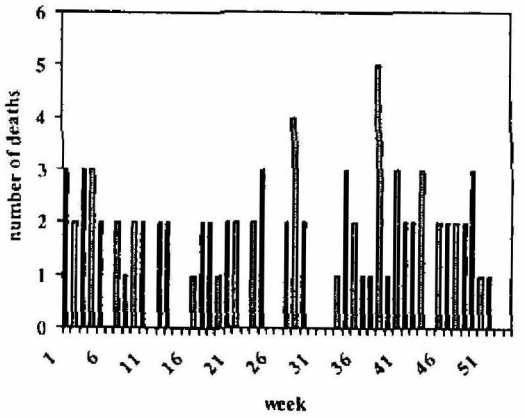
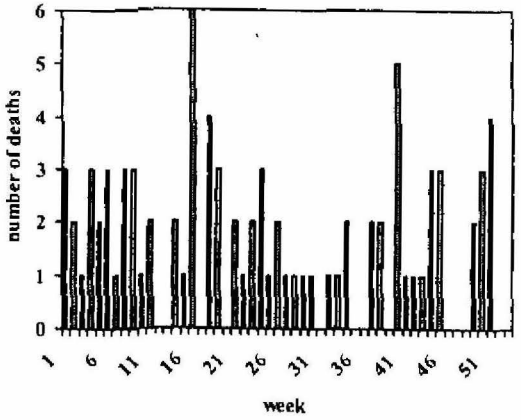
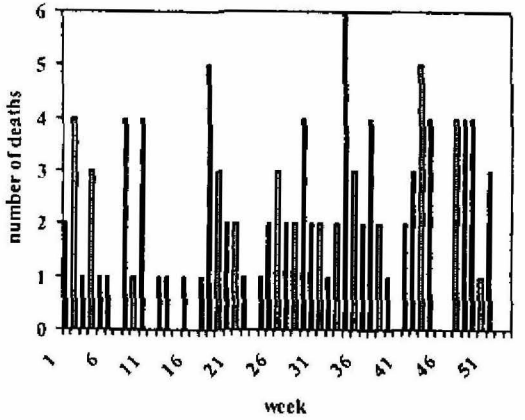


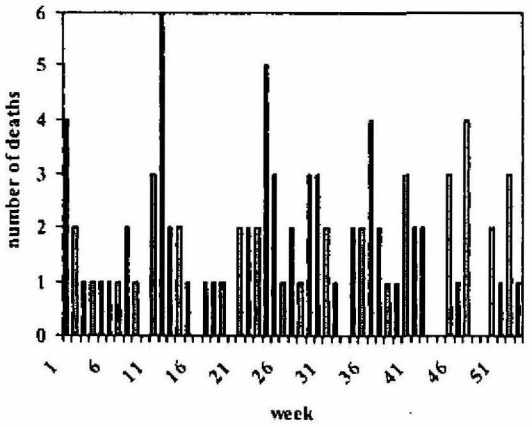
3.10. Deaths in 1996



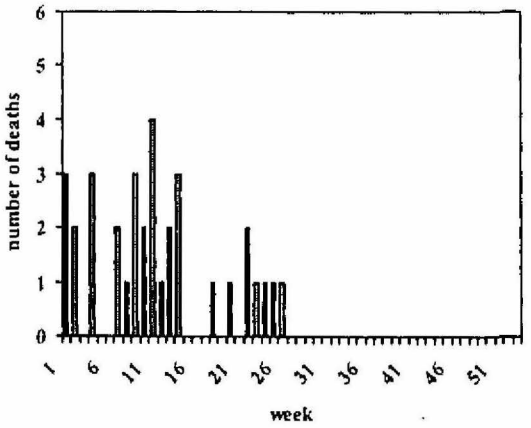
3.11. Deaths in 1997



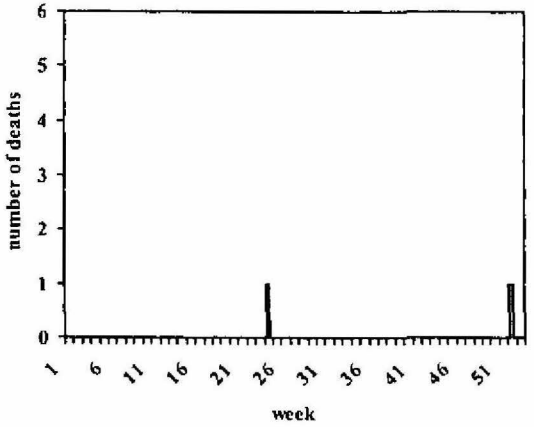
3.12. Deaths in 1998



3.13. Deaths in 1999



3.14. Deaths in 2000



3.15. Deaths in 2001

6. Patients on Code A 's wards

In some cases, doctors other than Code A issued MCCDs for patients who died on wards specifically served by Code A in her role as Code A in the Department of Medicine for Elderly People. These wards were Redclyffe Annexe, and Dryad and Daedalus wards. Code A also cared for some patients in the male and female wards, but these wards were not exclusive to patients of the Department. The completion of MCCDs by other doctors for patients in Redclyffe Annexe, or Dryad and Daedalus wards, could occur principally when Code A was on leave or not on duty. Therefore, the case mix of these patients would tend to be similar to those whose deaths were certified by Code A

Tables 3.8 and 3.9 show respectively the certificates issued by the other doctors at the hospital and Code A for deaths on different wards. These data reflect the fact that Code A ceased responsibility for patients in Redclyffe Annexe and took on the new Dryad and Daedalus wards 1993/4.

Table 3.8. Deaths certified by doctors other than Code A on wards at Gosport (Mulberry is a 40 bed assessment unit).

year	place of death								
	Gosport (ward not stated)	*Redclyffe*	*male ward*	*female ward*	*Daedalus ward*	*Dryad ward*	*Sultan ward*	*Mulberry*	*tota*
1987	66	9	9	11					95
1988	61	3	13	5					82
1989	52	3	3	10					68
1990	52	2	9	9					72
1991	37	1	10	11					59
1992	35	1	16	15					67
1993	34	2	3	6	3		8		56
1994	15	5			2		33		55
1995	12				12	5	35	10	74
1996	28	7			10	6	37	11	99
1997	10	3			8	7	45	33	100
1998	23	5			12	11	35	18	93
1999	12	7			6	9	27	10	71
2000	20	5			13	12	22	9	81
2001	59	8			1	4	25	6	103
	523	61	63	67	67	54	267	97	1175

Table 3.9. Deaths certified by Code A on different wards at Gosport.

year	place of death							Total
	Gosport (ward not stated)	*Redclyffe*	*male ward*	*female ward*	*Daedalus ward*	*Dryad ward*	*Sultan ward*	
1987	1	1						2
1988	2	6	11	1				20
1989	1	19	8	1				29
1990		23	13	2				38
1991		18	11	2				31
1992		23	8	1				32
1993		51	7	6	35			99
1994		58	1		42		4	105
1995	1	4			42	33	1	81
1996					48	32	3	83
1997					39	47		86
1998					51	51	5	107
1999					42	49	1	92
2000					15	17	2	34
2001						1	1	2
	5	203	59	13	314	230	17	841

The mean age of patients who died on each ward was different (Table 3.10). Patients in Redclyffe, Daedalus and Dryad wards tended to be older than those in the other wards. Greater proportions of patients who died in Redclyffe, Daedalus and Dryad wards were female than those who died in Sultan ward (Table 3.11).

Table 3.10. Mean age (years) of patients who died in different wards. (N=1799, p <0.005)

Ward	number	mean age	95 % confidence intervals
Gosport hospital, ward not specified	427	78.4	77.4 – 79.4
Redclyffe	250	82.8	81.8 – 83.7
Male ward	109	78.1	76.4 – 79.9
Female ward	68	80.3	77.7 – 82.8
Daedalus	381	82.5	81.8 – 83.2
Dryad	284	83.7	82.9 – 84.5
Sultan	280	77.0	75.6 – 78.4

Table 3.11. Numbers (%) of males and females who died in wards in Gosport hospital.

ward	gender		total
	male	*female*	
Gosport, ward not stated	244 (47.8)	266 (52.2)	510
Redclyffe	68 (26.2)	192 (73.8)	260
male ward	115 (96.6)	4 (3.4)	119
female ward		78 (100.0)	78
Daedalus ward	173 (46.1)	202 (53.9)	375
Dryad Ward	135 (47.7)	148 (52.3)	283
Sultan Ward	142 (51.1)	136 (48.9)	278
total	877 (46.1)	1026 (53.9)	1903

7. Certified cause of death

The certified cause of death could be determined from 2052 (99.2%) of the 2069 counterfoils available. Table 3.12 shows, for all deaths regardless of place of death in Gosport Hospital, the numbers of deaths certified as primarily due to one of six groups of conditions. Code A was more likely to give bronchopneumonia or stroke as the cause of death (Chi sq 529.6, df 5, P< 0.001). A potential explanation is case mix – patients with dementia or stroke would have been admitted to Redclyffe, Dryad and Daedalus wards. Another possibility is excess use of sedative medication, leading to development of bronchopneumonia.

Table 3.12. Cause of death in groups, according to whether Code A or other doctors signed the certificate.

Cause of death	Other doctors	Code A	total
cancer	460 (38.3)	50 (5.9)	510
heart	172 (14.3)	100 (11.8)	272
stroke	112 (9.3)	139 (16.4)	251
bronchopneumonia plus another	263 (21.9)	368 (43.3)	631
bronchopneumonia only	22 (1.8)	162 (19.1)	184
other	173 (14.4)	31 (3.6)	204
	1202	850	2052

It was possible to identify from the counterfoils 946 patients who had died in Daedalus, Dryad and Sultan wards. The admission criteria for these wards were different, and this is reflected in the differences in the certified causes of death among patients who died in these wards (Table 3.13). Since Code A was responsible for patients in Daedalus and Dryad wards, and general practitioners were responsible for patients in Sultan ward, it is possible that the differences observed in the certified causes of deaths between these doctors would be at least partly explained by the different characteristics of the patients they cared for.

Table 3.13. Numbers (%) of deaths certified as due to different causes on Daedalus, Dryad and Sultan wards (Chi Sq 344.8, df 10, p<0.005).

	ward			total
	Daedalus ward	*Dryad ward*	*Sultan ward*	
cancer	21 (5.5)	24 (8.5)	158 (56.0)	203
heart	51 (13.4)	37 (13.0)	36 (12.8)	124
stroke	95 (25.0)	29 (10.2)	10 (3.5)	134
bronchopneumonia plus another	135 (35.5)	103 (36.3)	44 (15.6)	282
bronchopneumonia only	56 (14.7)	65 (22.9)	13 (4.6)	134
other	22 (5.8)	26 (9.2)	21 (7.4)	68
	380	284	282	946

There were also variations in the certified causes of death according to the gender of patients, cancer being less frequently given as the cause of death among males, and bronchopneumonia alone more frequently among females (Table 3.14). However, this difference was not apparent when the analysis was confined to patients whose deaths had been certified by doctors other than Code A (Table 3.15).

Table 3.14. Numbers (%) of male and female patients certified as dying due to certain causes (Chi Sq 19.8, df 5, p<0.001)

cause of death	gender		total
	male	*female*	
cancer	244 (28.0)	241 (23.6)	485
heart	114 (13.1)	137 (13.4)	251
stroke	104 (12.0)	129 (12.6)	233
bronchopneumonia plus another	278 (32.0)	305 (29.9)	583
bronchopneumonia only	57 (6.6)	124 (12.1)	181
other	73 (8.4)	85 (8.3)	158
	870 (100.0)	1021 (54.0)	1891

Table 3.15. Numbers (%) of male and female patients certified by doctors other than Code A as dying due to certain causes (Chi 3.9, df 5, not significant).

cause of death	gender		total
	male	*female*	
cancer	218 (42.7)	219 (39.5)	437
heart	66 (12.9)	91 (16.4)	157
stroke	44 (8.6)	53 (9.5)	97
bronchopneumonia plus another	113 (22.2)	112 (20.2)	225
bronchopneumonia only	9 (1.8)	12 (2.2)	21
other	60 (11.8)	68 (12.3)	128
	510 (100.0)	555 (100.0)	1065

A comparison between certificates issued by Code A and the other doctors restricted to selected wards would reduce the likelihood that case mix would explain any observed differences. From 1987, 745 MCCDs were issued by Code A and 166 by other doctors for patients in Redclyffe Annexe and Daedalus and Dryad wards. The mean age of the patients was similar (Code A 83.0, the other doctors 82.5, not significantly different), as would be expected if the case mix had been the same. Among Code A s patients, 439 (59.5%) were females, and among the patients of the other doctors 103 (57.2%) were females (difference not statistically significant). However, the other doctors gave bronchopneumonia alone as the cause of death in only 3% of cases, but among Code A s patients the proportion was 20% (Chi Square 88.3, df 5, p 0.000) (Table 3.16).

Table 3.16. Causes of death among patients of Redclyffe Annexe, Daedalus and Dryad Wards, 1987-2001, comparing those certified by Code A and other doctors.

cause of death	ward					
	Redclyffe		Daedalus ward		Dryad ward	
	other	Code A	*other*	Code A	*other*	Code A
cancer	3 (5.9)	2 (1.0)	6 (9.2)	14 (4.5)	5 (10.0)	18 (7.9)
heart	7 (13.7)	12 (5.9)	11 (16.9)	40 (12.7)	6 (12.0)	31 (13.5)
stroke	8 (15.7)	23 (11.4)	18 (27.7)	77 (24.5)	4 (8.0)	25 (10.9)
bronchopneumonia plus another	23 (45.1)	125 (61.9)	17 (26.2)	118 (37.6)	19 (38.0)	84 (36.7)
bronchopneumonia only		36 (17.8)	1 (1.5)	55 (17.5)	4 (8.00)	58 (25.3)
other	10 (19.6)	4 (2.0)	12 (18.5)	10 (3.2)	12 (24.0)	13 (5.7)
	51	202	65	314	50	229

8. Hospital Episode Statistics

To determine whether there were a greater number of deaths than would have been expected among patients admitted to Gosport under the care of the Department of Medicine for Elderly People, a method is required for estimating the numbers of deaths that would have been expected. Since Gosport hospital is a community hospital, a comparison with other community hospitals would be a logical approach.

Information on admitted patient care delivered by NHS hospitals from 1989 is provided by Hospital Episode Statistics (HES), and HES were requested to provide information for this review. HES employs a coding system, each patient episode being assigned a series of codes that indicate the hospital in which care was provided, the type of speciality concerned, and the diagnosis. The codes are entered into a database in each NHS hospital, and the information is then collated at a national level by the Department of Health.

In order to identify those patients who were cared for in the Department of Medicine for Elderly People in Daedalus and Dryad wards at Gosport, specific codes indicating the speciality, hospital and ward would have been desirable. However, HES at a national level records information by hospital trust, but not necessarily by local hospital or specific ward. Thus, the national data do not allow the ready identification of patients who were cared for in the two wards at Gosport that are the focus of this review. Episode statistics that identified the ward were, however, available at Gosport hospital, but only relating to the years 1998 onwards. Consequently, data about most of the years of interest were not available.

Even if complete data for all the years of interest had been available, the difficulties would not have been resolved. The reason for employing HES data is to enable comparisons between the mortality rates in Gosport hospital with those of similar community hospitals elsewhere who were caring for similar groups of patients over the same period. The level of detail in the central HES data does not, however, permit the identification of a satisfactory group of comparable community hospitals and similar group of patients. For example, even when HES codes are selected that identify patients who have been transferred between hospitals following initial admission because of a stroke, the mortality rate (approximately 30%) is substantially lower than that in Gosport (see Table 4.3). An uncritical acceptance of this finding would lead to the conclusion that patients admitted to Gosport were more likely to die than if they had been admitted elsewhere, whereas in fact the patients who were admitted to Gosport were more severely ill than those in the best comparison group yet identified from the central HES data. The collection of episode statistics directly from a sample of community hospitals would ensure that more detailed information would be obtained. However, since a comparison would only be possible from 1998, and it would be impossible to eliminate the effects of case-mix among patients admitted to different hospitals, it would be impossible to place much confidence on the findings of such a comparison. Consequently, an analysis using HES data has not been undertaken in this review.

Discussion

Two points about the use of counterfoils as a source of data should be discussed first.

1) identification of all deaths

In this analysis of deaths identified from the counterfoils of MCCDs stored at Gosport hospital, some deaths may not be included, for example deaths referred to the coroner; in a few cases the doctor may not have issued the certificate from the Gosport hospital certificate book. However, a comparison with the numbers of certificates for deaths at the hospital completed by Code A and certificates identified by National Statistics shows the number to be virtually identical (Tables 3.1 and 6.1), and therefore the data from counterfoils are likely to be sufficiently complete to permit conclusions to be drawn.

2) completion of counterfoils

The writing of some doctors was difficult to read, and the signatures of many could not be interpreted. However, the counterfoils completed by Code A were easily identified. She had bold and confident handwriting, and used distinctive black ink. Also, occasional counterfoils were not fully completed, although this problem was uncommon and will not have influenced the findings of the analysis. Although Code A Code A usually specified the ward in which patients had died, other doctors often gave less detail and usually only indicated Gosport hospital as the place of death. However, this lack of detail is unlikely to have been systematic, and therefore it is possible to be reasonably confident in the findings of the comparison between deaths in different wards.

Findings

The analysis has identified the following concerns:

1. In her role as Code A in the Department of Medicine for Elderly People, Code A issued a large number of MCCDs between 1987 and 2000. Between 1988 and 1992, the numbers were between 29 and 38 per year, but from 1993 the numbers increased to between 81 and 107 per year, falling to 34 in 2000, the year in which Code A left the hospital in July. Dryad and Daedalus wards

opened in 1993-4, a factor that is likely to explain the increase in numbers of deaths in these years owing to differences in the types of patients admitted to these wards. Patients in Redclyffe Annexe commonly suffered from dementia, but those admitted to Dryad and Daedalus had a wider range of severe clinical problems.

2. The proportion of deaths certified by either Code A or other doctors occurring on each day of the week was more or less the same. In comparison with other doctors, Code A issued a lower proportion of MCCDs during the summer months, but this finding is likely to be explained by annual leave being taken during the summer months.
3. The case mix of patients is likely to explain most of the observed differences between MCCDs issued by Code A and those issued by other doctors. For example, patients under her care tended to be older than patients whose deaths were certified by other doctors.
4. It is notable that the patients admitted to Sultan ward, under the care of their general practitioners, were more likely to have been certified as dying due to cancer. They were also younger than patients who had died in Daedalus and Dryad wards.
5. The effect of case mix is probably reduced in an analysis that compared deaths in Redclyffe Annexe, Daedalus and Dryad wards that had been certified by Code A Code A or by other doctors. In this analysis, the mean age and proportion who were female was similar. However, Code A gave *bronchopneumonia alone* as the cause of death significantly more frequently than the other doctors. The review of records (Chapter Two) highlighted that patients who had been certified as having died of bronchopneumonia had had other significant conditions, including recent fractures of the hip. Furthermore, a high proportion of these patients had received opiates before death. Consequently, although case mix

almost certainly explains much of the difference between patients in the Department of Medicine for Elderly People managed by Code A and those under the care of other general practitioners, concerns about the use of opiates and the possible contribution they may have made to the deaths of some patients cannot be ruled out.

Chapter Four: Admissions to Dryad Ward

Introduction

The admissions book for Dryad ward has been retained by the hospital, and contained information about all admissions from 1993, the year of first opening of the ward. The information recorded in the book included dates of admission and discharge (or death), the time of day of deaths, some indication of the reasons for admission, and the place the patient had been admitted from. This information was studied in order to identify the characteristics of patients admitted to Dryad ward, and aspects of the care they had received.

It should be noted that Daedalus ward did not have a similar book, although a day-book appears to have been employed. This did not contain information helpful to this review.

Methods

There had been a total of 715 admissions from the opening of the ward in 1993 until the end of 2001. The admissions book recorded the date of admission and the date of discharge or death, and it was therefore possible to calculate the length of admission. Table 4.1 shows the mean length of admissions by year of admission, for the 676 (94.5%) admissions in which the admission and discharge date could be identified. There was some variation between years, with admissions during 1998 having the shortest mean length.

Table 4.1. Mean length (days) of stay on Dryad ward, days, 1993-2001.

year	number of admissions	mean (days)	95% CI for mean		minimum	maximum
			Lower	Upper		
1993	37	148.6	87.6	209.5	4	652
1994	68	41.7	24.7	58.7	1	326
1995	52	88.8	41.9	135.6	1	856
1996	43	56.0	33.6	78.3	1	345
1997	67	33.9	19.3	48.6	1	365
1998	103	36.0	28.1	43.9	0	195
1999	131	42.5	32.4	52.6	0	406
2000	90	65.8	47.4	84.2	1	487
2001	85	67.5	48.5	86.6	4	409
Total	676	57.1	50.0	64.1	0	856

The mean age of patients on admission to Dryad ward is shown in Table 4.2, according to year of admission, for the 708 (99.0%) cases in which the patient's age could be identified. There was no significant difference between years. The admissions book did not record the gender of patients, but gender could be inferred from the names of 712 (99.5%) of the 715 cases. Of these 414 (58.1%) were female.

Table 4.2. Mean age (yrs) at admission to Dryad ward, 1993-2001.

year	number of admissions	mean (yrs)	95% CI for mean		minimum	maximum
			Lower	Upper		
1993	38	82.1	79.7	84.4	66.0	97.0
1994	75	83.7	82.0	85.3	64.4	100.0
1995	56	82.6	80.6	84.5	66.9	99.0
1996	45	83.0	81.0	84.9	69.8	95.2
1997	71	81.8	79.9	83.8	66.3	98.0
1998	105	83.2	81.7	84.6	67.1	100.0
1999	133	83.6	82.3	84.8	65.0	98.2
2000	89	82.7	81.2	84.2	67.0	100.0
2001	96	80.9	79.2	82.6	61.0	100.0
Total	708	82.7	82.1	83.21	61.0	100.0

The Dryad ward admissions book recorded whether the patient died or was discharged. Table 4.4 indicates that the proportion of patients who were discharged

alive was less than 50% until 1999. Between 1993-5, 80% of admitted patients died on the ward.

Table 4.3. Numbers (%) of admissions followed by death or discharge, Dryad ward, 1993-2001.

year	Outcome		Total
	died	discharged	
1993	29 (80.6)	7 (19.4)	36
1994	59 (84.3)	11 (15.7)	70
1995	42 (80.8)	10 (19.2)	52
1996	31 (70.5)	13 (29.5)	44
1997	48 (69.6)	21 (30.4)	69
1998	64 (61.5)	40 (38.5)	104
1999	58 (43.9)	74 (56.1)	132
2000	35 (38.5)	56 (61.5)	91
2001	39 (45.3)	47 (54.7)	86
	405	279	684

The causes of death of patients of Dryad certified by Code A are shown in Table 4.4. These data were taken from the MCCD counterfoils (see Chapter Three).

Table 4.4. Deaths on Dryad ward certified by Code A

Cause of death							Total
	cancer	*heart*	*stroke*	*bronchopneumonia plus another*	*bronchopneumonia only*	*other*	
1995	2	4	2	15	8	1	32
1996	1	3	5	17	5	1	32
1997	2	11	4	23	6	1	47
1998	3	4	6	15	18	5	51
1999	7	6	5	12	15	4	49
2000	3	2	3	2	6	1	17
2001					1		1
	18	30	25	84	59	13	229

The admissions book recorded brief information about the patient's illnesses at the time of admission. On a few occasions, this information included an indication of the reason for admission, for example respite care. Table 4.5 summarizes the findings. Medical/mental problems refer in the Table to either dementia or a mix of medical conditions with the additional problem of confusion or dementia; "post-op" indicates people who have had a recent operation, most commonly surgery following a fractured hip.

Table 4.5. Numbers (%) cases admitted to Dryad ward with different primary problems, 1993-2001.

Year	Diagnostic group							Total
	stroke	*general medical problems*	*medical/ mental problems*	*heart problems*	*Cancer*	*post op*	*respite care/social admission*	
1993	9 (23.7)	19 (50.0)	6 (15.8)	2 (5.3)	2 (5.3)			38
1994	10 (13.5)	31 (41.9)	14 (18.9)	2 (2.7)	3 (4.1)	14 (18.9)		74
1995	7 (12.5)	23 (41.1)	13 (23.2)		7 (12.5)	5 (8.9)	1 (1.8)	56
1996	1 (2.5)	20 (50.0)	10 (25.0)		7 (17.5)	2 (5.0)		40
1997	4 (5.7)	29 (41.4)	16 (22.9)	5 (7.1)	8 (11.4)	8 (11.4)		70
1998	6 (5.8)	42 (40.4)	11 (10.6)	3 (2.9)	9 (8.7)	23 (22.1)	10 (9.6)	104
1999	10 (7.6)	47 (35.9)	10 (7.6)	6 (4.6)	11 (8.4)	38 (29.0)	9 (6.9)	131
2000	8 (9.0)	38 (42.7)	8 (9.0)	2 (2.2)	10 (11.2)	20 (22.5)	3 (3.4)	89
2001	11 (12.4)	30 (33.7)	16 (18.0)	1 (1.1)	8 (9.0)	9 (10.1)	14 (15.7)	89
Total	66	279	104	21	65	119	37	691

General medical problems were the commonest reason for admission in all years, but the proportion of admissions for other problems varied. Stroke was a relatively common reason for admission in 1993, and dementia with or without other medical problems was also relatively common until 1998. The proportion of patients who had been admitted following surgery increased from 1998, as did admissions for respite care.

The admissions book also recorded information about the source of admission. This information is summarised in Table 4.6. Dolphin Day Hospital is the day hospital based in Gosport War Memorial Hospital.

Table 4.6. Sources of admission to Dryad ward, 1993-2001.

year	home	rest/nursing home	acute hospital	Sultan ward	another ward at Gosport	Dolphin day hospital	
1993	4 (10.5)	2 (5.3)	23 (60.5)	8 (21.1)	1 (2.6)		38
1994	8 (10.7)	2 (2.7)	56 (74.7)	8 (10.7)	1 (1.3)		75
1995	6 (10.9)	2 (3.6)	42 (76.4)	3 (5.5)	1 (1.8)	1 (1.8)	55
1996	2 (4.4)	4 (8.9)	36 (80.0)	2 (4.4)	1 (2.2)		45
1997	3 (4.2)		56 (78.9)	7 (9.9)	3 (4.2)	2 (2.8)	71
1998	13 (12.4)		82 (78.1)	4 (3.8)	5 (4.8)	1 (1.0)	105
1999	19 (14.4)	2 (1.5)	103 (78.0)	1 (0.8)	4 (3.0)	3 (2.3)	132
2000	8 (8.8)	1 (1.1)	76 (83.5)	1 (1.1)	4 (4.4)	1 (1.1)	91
2001	23 (24.5)	2 (2.1)	49 (52.1)	8 (8.5)	12 (12.8)		94
Total	86	15	523	42	32	8	706

Most patients admitted to Dryad ward had been transferred from acute hospitals. Only in 2001 did the proportion of admissions directly from home approach 25%, a finding that is likely to be partly explained by the increase in admissions for respite care (Table 4.5).

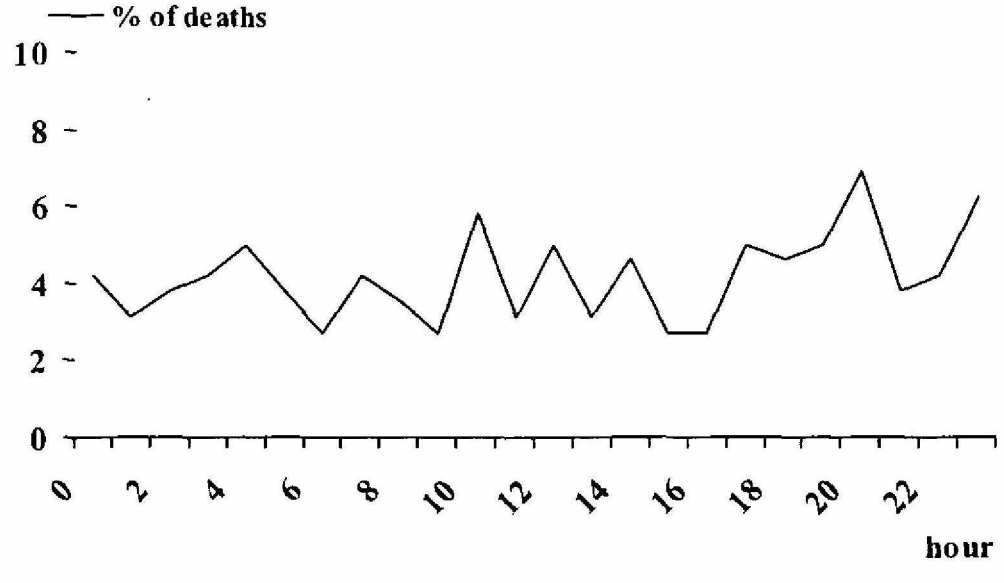
The time of death had been recorded in the admissions book in 260 cases (64.2% of the 405 deaths on the ward). Deaths are reasonably equally distributed among hours of the day (Table 4.7 and Figure 4.1).

Table 4.7. Time of death (data recorded in only cases only).

hour	year of admission									total
	1993	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	
0	1 (5.0)	4 (11.4)		1 (5.9)	1 (3.3)			4 (15.4)		11 (4.2)
1	1 (5.0)	2 (5.7)	2 (6.7)	1 (5.9)		1 (2.3)			1 (4.3)	8 (3.1)
2	1 (5.0)	1 (2.9)	3 (10.0)		1 (3.3)	2 (4.5)	1 (2.9)	1 (3.8)		10 (3.8)
3	1 (5.0)	1 (2.9)			1 (3.3)	2 (4.5)	5 (14.3)	1 (3.8)		11 (4.2)
4		3 (8.6)	2 (6.7)		2 (6.7)	1 (2.3)	3 (8.6)	1 (3.8)	1 (4.3)	13 (5.0)
5	1 (5.0)		1 (3.3)	1 (5.9)	2 (6.7)	2 (4.5)		2 (7.7)	1 (4.3)	10 (3.8)
6			1 (3.3)		2 (6.7)	3 (6.8)			1 (4.3)	7 (2.7)
7	1 (5.0)	2 (5.7)	2 (6.7)	1 (5.9)	3 (10.0)		1 (2.9)	1 (3.8)		11 (4.2)
8		2 (5.7)	1 (3.3)	2 (11.8)	1 (3.3)				3 (13.0)	9 (3.5)
9	1 (5.0)				1 (3.3)	3 (6.8)	1 (2.9)		1 (4.3)	7 (2.7)
10	1 (5.0)	3 (8.6)	1 (3.3)		2 (6.7)	5 (11.4)	2 (2.7)		1 (4.3)	15 (5.8)
11	2 (10.0)		1 (3.3)	1 (5.9)	1 (3.3)	1 (2.3)	1 (2.9)		1 (4.3)	8 (3.1)
12			2 (6.7)	2 (11.8)	4 (13.3)	2 (4.5)		2 (7.7)	1 (4.3)	13 (5.0)
13		3 (8.6)		2 (11.8)	1 (3.3)	2 (4.5)				8 (3.1)
14	2 (10.0)	1 (2.9)			1 (3.3)	3 (6.8)	1 (2.9)	3 (11.5)	1 (4.3)	12 (4.6)
15		1 (2.9)	1 (3.3)		2 (6.7)		2 (5.7)	1 (3.8)		7 (2.7)
16						1 (2.3)	2 (5.7)	2 (7.7)	2 (8.7)	7 (2.7)
17	1 (5.0)	1 (2.9)	2 (6.7)	1 (5.9)	1 (3.3)	2 (4.5)	2 (5.7)	1 (3.8)	2 (8.7)	13 (5.0)
18		2 (5.7)	2 (6.7)	2 (11.8)		1 (2.3)	3 (8.6)	2 (7.7)		12 (4.6)
19	4 (20.0)	1 (2.9)	2 (6.7)	1 (5.9)		1 (2.3)	3 (8.6)		1 (4.3)	13 (5.0)
20	1 (5.0)	2 (5.7)	3 (10.0)	2 (11.8)		1 (2.3)	3 (8.6)	3 (11.5)	3 (13.0)	18 (6.9)
21		1 (2.9)			2 (6.7)	3 (6.8)	2 (5.7)		2 (8.7)	10 (3.8)
22	1 (5.0)	2 (5.7)	2 (6.7)		1 (3.3)	3 (6.8)	1 (2.9)	1 (3.8)		11 (4.2)
23	1 (5.0)	3 (8.6)	2 (6.7)		1 (3.3)	5 (11.4)	2 (5.7)	1 (3.8)	1 (4.3)	16 (6.2)

Total	20	35	30	17	30	44	35	26	23	260

Figure 4.1. The percentage of deaths on Dryad ward, 1993-2001, in each hour of the day (n=260).



Discussion

Some qualifications about the admissions book as a source of date must be noted. There were occasional errors in the book, for example the admissions of some patients had not been entered on the day of admission, and some information was occasionally missing, for example the source of admission. Nevertheless, the book was generally complete, and can be assumed to represent a reasonable description of admissions throughout the period.

The information from the admissions book reveals a changing pattern of cases being admitted to Dryad ward. Most patients were admitted from acute hospitals and with general medical problems, dementia or after surgery. However, from 1998, the proportion with dementia decreased, and there were increases in the proportions of admissions that were for respite care or following surgery. These changes in case

mix are important when interpreting changes in mortality. The proportions of admissions that ended in death declined from 1997. However, the annual number of admissions increased, and consequently the total numbers of deaths did not decrease until 2000. It is not possible to describe in detail the changes in case mix of patients admitted to Daedalus and Sultan wards, but it is almost certain that changes did occur. There may also have been changes in case mix in the period 1988 – 1993 with respect to admissions to Redclyffe Annexe, and the male and female wards. If follows that any comparisons in mortality rates between those in the wards of the Department of Medicine for Elderly People at Gosport or between Gosport and other community hospitals must be interpreted with considerable caution.

More or less similar proportions of patients died in each hour, as would normally be expected. The finding of a predictable distribution of deaths throughout the hours of the day serves to reduce concern about the possibility of sudden death following the *administration of lethal drug doses.*

Chapter Five: Prescribing of opiate drugs

Introduction

Many of the concerns about deaths at Gosport War Memorial Hospital relate to the use of opiates. The misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 1985 stipulate that registers are kept of the administration of opiate drugs such as diamorphine, morphine and fentanyl. Registers must be bound, and entries must be in chronological order. This Chapter describes an investigation of the information contained in the controlled drug registers retained at Gosport Hospital.

Method

The surviving controlled drugs registers used at the hospital were obtained and reviewed. The relevant registers that were still available are shown in Table 5.1. No data were available from the male ward. Comparisons between wards were possible for some years, although the data were not always complete.

The controlled drug registers contained a record of every dose of opiate drug administered to each patient. It was possible to identify the first and last doses of each drug administered, and the quantity of drug in each dose.

Table 5.1. The periods for which controlled drug registers from different wards were available.

Ward	Dryad	Daedalus	Sultan	Redclyffe	Female ward	Male ward
Period covered by registers	25.6.95 – 5.3.02	6.10.96 – 14.8.02	13.7.94 – 31.10.01	27.2.93 – 28.10.95	30.8.87 – 8.9.94	No register available

Results

1. Numbers of patients who died who received opiates

Information was available from both the MCCD counterfoils (see Chapter Three) and the controlled drug registers, and it was possible to identify those who had received opiates during their final illness by matching counterfoils and register entries. The years 1997-2000 were selected, since the controlled drug register data from Dryad, Daedalus and Sultan were complete for this period. Table 5.2 shows the numbers and proportions of cases given an opiate before death, according to whether the MCCD was signed by Code A or another doctor. A greater proportion of patients of Code A received an opiate (Chi Square = 30.1; df 1, p <0.001).

Table 5.2. Numbers (%) of patients dying 1997-2000 who were prescribed at least one dose of an opiate before death.

Doctor signing MCCD	Opiate prescribed		Total
	yes	*no*	
Code A	211 (74.0%)	74 (26.0%)	285
Another doctor	146 (51.8%)	136 (48.2%)	282
Total	357 (63.0%)	210 (37.0%)	567

Code A was more likely to prescribe an opiate to patients who were certified as dying from bronchopneumonia with other conditions, bronchopneumonia alone, or other conditions (Table 5.3). In the Table, all the certified causes of death have been grouped into the six categories employed in Chapters Two and Three.

Table 5.3. The numbers (%) of patients dying 1997-2000 from groups of conditions who had been prescribed an opiate by Code A or other doctors.

Cause of death	doctor	opiate		total	Sig (df 1)
		yes	*no*		
Cancer	Code A	15 (68.2%)	7 (31.8%)	22	0.2
	Another	78 (80.4%	19 (19.6%)	97	
Heart	Code A	26 (59.1%)	18 (40.9%)	44	0.58
	Another	11 (36.7%)	19 (63.3%)	30	
Stroke	Code A	37 (69.8%)	16 (30.2%)	53	0.19
	Another	16 (55.2%)	13 (44.8%)	29	
bronchopneumonia with other conditions	Code A	64 (76.2%)	20 (23.8%)	84	0.001
	Another	27 (37.5%)	45 (62.5%)	72	
bronchopneumonia only	Code A	57 (83.8%)	11 (16.2%)	68	0.01
	Another	3 (42.9%)	4 (57.1%)	7	
other conditions	Code A	12 (85.7%)	2 (14.3%)	14	0.001
	Another	10 (21.7%)	36 (78.3%)	46	

The analysis in Table 5.3 was repeated for all deaths that occurred in Redclyffe Annexe up to and including 1994. Patients in the Annexe were generally the elderly mentally infirm, and Code A was the responsible doctor at the Annexe until approximately 1994 (see Table 3.9). The findings do not indicate differences in use of opiates between Code A and the other doctors, although none of the other doctors gave bronchopneumonia alone as the cause of death in this period. However, a comparison involving deaths in Redclyffe from 1995 indicates leads to different findings. None of the patients whose deaths were certified by other doctors had received an opiate, although all three of those certified by Code A had (Table 5.5). A test of statistical significance has not been performed since the numbers of cases involved was small. However, there does appear to have been a change in the use of opiates at the end of life at about the time Code A ceased to have principal

Table 5.4. The numbers (%) of patients dying 1993-1994 in Redclyffe Annexe from different causes who were prescribed an opiate by Code A or other doctors.

Cause of death	doctor	opiate		total	sig
		Yes	no		
Cancer	Code A	1 (50.0)	1 (50.0)	2	0.17
	Another		3 (100.0)	3	
Heart	Code A	5 (41.7)	7 (58.3)	12	0.24
	Another	1 (16.7)	5 (83.3)	6	
Stroke	Code A	6 (27.3)	16 (72.7)	22	0.93
	Another	1 (25.0)	3 (75.0)	4	
Bronchopneumonia with other conditions	Code A	41 (33.1)	83 (66.9)	124	0.39
	Another	3 (50.0)	3 (50.0)	6	
Bronchopneumonia Only	Code A	23 (65.7)	12 (34.3)	35	-
	Another	-	-	0	
Other conditions	Code A		10 (100.0)	10	-
	Another		3 (100.0)	3	

Table 5.5. Numbers (%) of patients dying from different causes in Redclyffe Annexe, 1995 or later.

Cause of death		opiate		total
		yes	no	
Heart	other		1 (100.0)	1
	Code A		1 (100.0)	1
Stroke	other		4 (100.0)	4
	Code A	1 (100.0)		1
bronchopneumonia plus another	other		17 (100.0)	17
	Code A	1 (100.0)		1
bronchopneumonia only	other			
	Code A	1 (100.0)		1
		1 (100.0)		1
Other	other		5 (100.0)	5

responsibility for patients in Redclyffe Annexe. One explanation for this finding is that the type of patients being cared for in the Annexe changed at the same time, but an alternative is that the practice of almost routine use of opiates before death was discontinued.

2. Deaths on Dryad ward

Since information was available about admissions to Dryad ward, including some indication of the reason for admission, and whether the patient was discharged alive or had died on the ward, it has been possible to estimate the proportions of patients admitted with different types of illnesses who received opiates, and whether they died. Those patients who received at least one dose of opiate were included in this analysis.

The findings are summarized in Table 5.6. The illness groups are stroke, general medical problems, medical and mental problems, heart problems, cancer, post-operative cases such as fractured neck of femur, and respite care. Thus, of the 17 patients admitted with strokes between March 1995 and August 1998, 10 died, of whom 8 received an opiate. None of those discharged alive had received an opiate. Some patients in all illness groups received an opiate except for those in the respite care group. Of those who were admitted with strokes, 47% received an opiate, the proportion for general medical problems was 71.7%, medical and mental problems 73.2%, heart problems 71.4%, cancer 66.7 %, and post-operative cases 60.9%.

Some qualifications must be made about these data. First, 10 patients had been recorded as receiving an opiate although the admissions book did not record them

as having been admitted. These patients were omitted from the analysis. The most likely explanation is that these patients were on a different ward, the drugs been transferred between wards. Second, no account has been made of the dose, numbers of doses, type of opiate received or administration route. The data will

Table 5.6. Patients on Dryad ward who received an opiate, March 1995 – August 1998, according to illness group and outcome (died or discharged). N=209.

illness group	had an opiate	Outcome		Total
		died	*discharged*	
stroke	No	2 (22.2)	7 (77.8)	9
	yes	8 (100.0)		8
	total	10 (58.8)	7 (41.2)	17
general medical problems	No	7 (26.9)	19 (73.1)	26
	yes	55 (83.3)	11 (16.7)	66
	total	62 (67.4)	30 (32.6)	92
medical/mental problems	No	3 (27.3)	8 (72.7)	11
	yes	29 (96.7)	1 (3.3)	30
	total	32 (78.0)	9 (22.0)	41
heart problems	No		2 (100.0)	2
	yes	5 (100.0)		5
	Total	5 (71.4)	2 (28.6)	7
cancer	No	5 (62.5)	3 (37.5)	8
	yes	16 (100.0)		16
	Total	21(87.5)	3 (12.5)	24
post op	No	3 (33.3)	6 (66.7)	9
	yes	12 (85.7)	2 (14.3)	14
	Total	15	8	23
respite care/ social admission	No		5 (100.0)	5

Total	5 (100.0)	5

therefore include a number of patients who received only one or two doses, although this would be unlikely to change the general conclusion from the table. Third, it is difficult to judge whether individual patients did have a level of pain that justified the use of opiate medication. Without a case by case review, the appropriateness of opiate medication for each patient cannot be determined.

3. Quantities of opiates prescribed per patient

An analysis was undertaken to compare the total amount of opiate prescribed per patient by Code A and other doctors at Gosport. A random sample of patients who had died, and who had been prescribed an opiate, was identified, from those who had died on Dryad, Daedalus or Sultan wards, and for whom complete data from controlled drug registers were available. A total of 46 patients were included, 21 being patients whose deaths had been certified by Code A and 25 whose deaths had been certified by other doctors. Seventeen patients had died on Dryad ward, nine on Daedalus ward, and 20 on Sultan ward. The amount of opiate prescribed for a patient was calculated by identifying the number of doses, and quantity of drug in each dose, for each drug administered to each patient. Thus, if a patient had been administered subcutaneous diamorphine 20 mgm per day for three days, the total amount would be 60 mgm.

There was no significant difference in the total amount in mgms of diamorphine recorded as administered during the terminal illness, the mean for Code A s patients being 113 mgms (SD 211 mgms) in comparison with 1300 mgms (SD 3354 mgms) for the other doctors (t-test p 0.13). The mean quantity of oramorph for Code A

Code A's patients was 276 mgms (SD 276 mgms) and for the other doctors 169 mgms (SD 168 mgms) (t-test p 0.6). None of Code A's patients in the sample had received morphine sulphate tables, although seven in the comparison group had. One patient of Code A had received fentanyl, and one patient of the other doctors had received methadone.

Some caution is needed in drawing definitive conclusions from this analysis since it did not involve review of the clinical records, and the sample was small. Nevertheless, the findings do not suggest that Code A's patients had received opiates for prolonged periods.

Discussion

The findings of the review of prescribing of controlled drugs indicate that patients in Gosport Hospital whose deaths were certified by Code A were more likely to have been prescribed an opiate (most commonly diamorphine or oramorph). The excess was most evident among patients who were certified as dying from bronchopneumonia with or without other conditions, or from some other condition that was not cancer or cerebro- or cardio-vascular disease. This finding is a cause for concern, since the use of opiates for pain relief in terminal care is more common in conditions in which pain would be expected, in particular cancer. Furthermore, a high proportion of the initial cases referred to the police by concerned relatives had been certified as dying due to bronchopneumonia. It does appear that the practice of almost routine use of opiates before death in Redclyffe Annexe changed when Code A Code A ceased principal responsibility for patients in the Annexe. This may have been a consequence of a change in the practice followed by the doctors who took

over from Code A , or a change in the mix of patients who were admitted to the Annexe.

The finding that the quantities of opiate prescribed, in the analysis of a random sub-sample, did not indicate that Code A had prescribed opiates over prolonged periods is reassuring. However, this finding does not eliminate the possibility that some patients were given opiates unnecessarily. Therefore, the findings of the analyses reported here are consistent with a practice of prescribing opiates to an inappropriately wide group of older patients.

Chapter Six: Analysis of medical certificates of cause of death (MCCDs)

Introduction

This Chapter presents the findings of an analysis of numbers of deaths in general practice certified by Code A. The aim was to determine whether there were greater numbers of deaths than would have been expected, and therefore reasons for concern about the care of patients in general practice. Although most of the review is concerned with deaths in Gosport hospital, it was necessary to be certain that there were no reasons for concern about deaths in the community.

Methods

The data relate to the deaths certified by Code A and a sample of general practitioners chosen because they were caring for similar groups of patients in Gosport at the same time as Code A There were nine general practices in Gosport, one of which was the practice of Code A and her partners (referred to as the index practice). Levels of deprivation were classified into four levels. In the index practice 6.9% of registered patients were classified in one of the four levels (0.4% in the highest level of deprivation), but in the first control practice 8.4% (2.5% in the highest level) and in the second control practice 7.9% (0.5% in the highest level) were classified in one the deprivation levels. Thus, the comparison practices had a marginally higher proportion of deprived patients. In the index practice, 15.6% of patients were aged 65 years or over; in the first control practice 11.3% and in the second control practice 18.3% of patients were aged 65 years or over. Consequently, the analysis took account of the differences in the age of patients

between practices, but did not account for deprivation since the differences were small.

The MCCDs were identified by National Statistics (see Chapter Two). Deaths from 1993 onwards certified by any of the general practitioners of the three practices were identified using the computer database maintained by National Statistics. Deaths prior to 1993 have not been stored on computer, and therefore a hand search was required of the notifications in the death register of files completed in the registration districts serving the Gosport area (Gosport, Fareham 1, and Havant). The data from these sources had been provided by registrars from the death certificates completed by the general practitioners and additional information provided by the person reporting the death to the registrar (the informant). In this review, information from each death notification was entered into a database for analysis.

The deaths certified by the general practitioners included those that had occurred at home, in nursing homes, or in hospitals, in particular Gosport War Memorial Hospital.

Results

Table 6.1 presents information about the numbers of deaths certified by the sample of GPs who were partners in one of the three practices included in this analysis. The figures for Code A are similar to those identified from certificate counterfoils held at the hospital (see Table 3.2).

Table 6.1. Annual number of deaths, 1987-2002.

year	certifying doctor																					tota
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Code A	
1987	8	20	7					6	10	11	13			2	15	12	3	9	11		17	2	14
1988	4	8	4					10	12	10	11				5	8	5	5	6	1	15	28	13
1989	4	11	10					20	9	13	14				6	9	8	8	5	2	9	39	16
1990	20	11	7	5				8	17	13	17				10	13	1	4	4			41	17
1991	16	20	13	9				7	5	12	11				11	10	7	5				37	16
1992	5	10	8	18				9	10	8	13				9	10	3	5				36	14
1993	8	10	13	7	3			8	9	7	11	1			5							97	17
1994	4	8	5	9	4			12	4	5	12				9							106	17
1995	7	12	8	9	2			8	10	18	9	13	9		6							81	19
1996	15	9	11	11	7			10	5	9	5	11	9									86	18
1997	7	6	3	10	5	1		19	13	5	9	6	8									92	18
1998	5	9	7	10	5	8		2	13	9	15	12	14									108	21
1999	7	9	4	10	4	12	8	2	9	13	9	1	7									94	18
2000	3	5	5	7	5	11	4		7	6	13	7										35	10
2001	7	17	9	1	1	13	2	1	5	4	6	8	1									5	8
2002	9	8	4	9	5	8	5	7	5	5	5	10											8
	129	173	118	115	41	53	19	129	143	148	173	69	48	2	76	62	27	36	26	3	41	887	251

Deaths in Gosport hospital

Code A 's partners provided cover at Gosport hospital during her absences (due to vacations and other reasons). Figures 3.1 to 3.15 reveal periods of one or more weeks in which Code A did not issue a certificate for a patient who had died in Gosport hospital, and one explanation for these weeks is that she was on vacation. A comparison of death certification rates by her partners, relating to patients on Daedalus and Dryad wards during those periods of absence, with certification rates by Code A on the same wards when she was present would be of particular interest. A high death rate when Code A was present and a lower rate when she was on leave would raise questions about the impact of her clinical practice on mortality rates.

However, some difficulties of interpretation might remain since mortality during her absences could in part reflect effects of her practice when present, possibly leading to attenuation of observable differences. Also, the delay of the admission of

seriously ill patients until Code A s return may serve as an explanation for differences in deaths rates between normal and holiday periods. Unfortunately, it has proved impossible to obtain information about the doctors' rota for Daedalus and Dryad wards and the analysis reported below differs from a straightforward comparison in two respects:

a) Since individual wards cannot be consistently identified from the place of death details on the certificates, the analysis relates to deaths from all wards at Gosport certified by Code A or her partners. These include deaths of patients in Sultan ward who would have been under the care of their general practitioner as well as deaths in Dryad and Daedalus wards, under the care of the Department of Medicine for Elderly People.

b) Since records of Code A s rota are no longer available, an indirect method of inferring (some of) these periods of absence has been used, as described below, but the validity of this method cannot be verified directly.

Absence of Code A has been inferred from prolonged periods between consecutive deaths certified by her. Such periods could of course occur by chance even when Code A is present. A variety of period lengths has been investigated. The principal results below are based on periods of at least 14 consecutive days, since use of shorter periods are more prone to error, such as uncertainty over the exact start and end dates.

Rates of certification by Code A except during those periods in which there was at least 14 days between successive certifications by her, were compared with rates of certification by the seven other practice partners in those same 14+ day periods. Incidence ratios (and 95% confidence intervals) were: 1.67 (0.88-3.59) in 1998, 3.78 (1.91-8.52) in 1999, and 1.25 (0.49-4.11) in 2000. If the three 1998-2000 years were considered together, the incidence ratio was 2.24 (1.47-3.55).

In interpreting these ratios, it is helpful to consider the magnitude and direction of possible biases. End-estimate bias in the 14-day intervals is unlikely to exceed 15% (two end days in 14 days); they could operate in either direction (that is increasing or decreasing the true estimate). If Code A had been absent for periods shorter than 14 days, this will lead to under estimation of her rates. If the 14+ day periods are chance occurrences not corresponding to her absence, her rates will be overestimated, by up to 30%. If, as noted earlier, Code A 's practice while present impacted on her partners' certification rates during her absence, the incidence ratio might be reduced.

Taking these factors into account, it is difficult to draw secure conclusions. The incidence ratio in 1999 was markedly raised, and this finding may point to a method for exploring further any potential impact of Code A s clinical practice on mortality rates. It has not been possible to obtain reliable information about holiday periods in this review, but this may be possible in the continuing police investigation, in which case the pilot analysis included here should be repeated using valid holiday data.

Deaths at home or in nursing or residential homes

Table 6.2 presents information relating to deaths at home, or in residential or nursing homes, certified by the same group of GPs. Since Code A was required to care for patients in Gosport War Memorial Hospital, she may be expected to have undertaken a reduced workload in the general practice. The findings indicate that Code A Code A issued fewer certificates than most of the other GPs, although some (probably part-timers, or doctors leaving general practice between 1993-5) issued fewer. This finding is reassuring, since it reduces concern about care given to patients in the community. It is notable that Code A issued no certificates in 2002.

Table 6.2. Annual number of deaths at home or in residential/nursing homes certified by GPs, 1987-2002.

year	certifying doctor																					total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Code A	
1987	4	13	7					4	6	7	10			2	10	9	3	5	4		10	2	96
1988	1	6	2					9	10	6	8				3	5	4	5	6	1	10	9	85
1989	3	7	7					20	6	5	11				5	6	8	6	3	2	9	9	107
1990	12	6	5	3				7	15	9	11				7	7	1	4	3			3	93
1991	15	15	10	7				7	4	9	9				10	5	7	4				5	107
1992	2	6	6	10				7	8	5	11				6	6	2	4				4	77
1993	5	7	10	5	1			6	7	5	8	1			5							3	63
1994	1	5	4	7	4			9	3	3	10				5							2	53
1995	4	9	6	7	2			8	6	8	7	10	2		3							1	73
1996	10	5	6	8	5			7	3	3	4	6	1									2	60
1997	5	1	1	10	1			15	9	2	6	3	3									6	62
1998	5	7	6	9	1	6		1	8	4	6	9	4									1	67
1999	6	6	3	7	4	10	7		5	4	6	1	5									2	66
2000	2	3	4	4	4	11	2		5	5	7	6										1	54
2001	6	13	8	1	1	11	2	1	2	3	5	7	1									3	64
2002	9	7	3	7	1	7	5	3	4	4	4	7											61
	90	116	88	85	24	45	16	104	101	82	123	50	16	2	54	38	25	28	16	3	29	53	1188

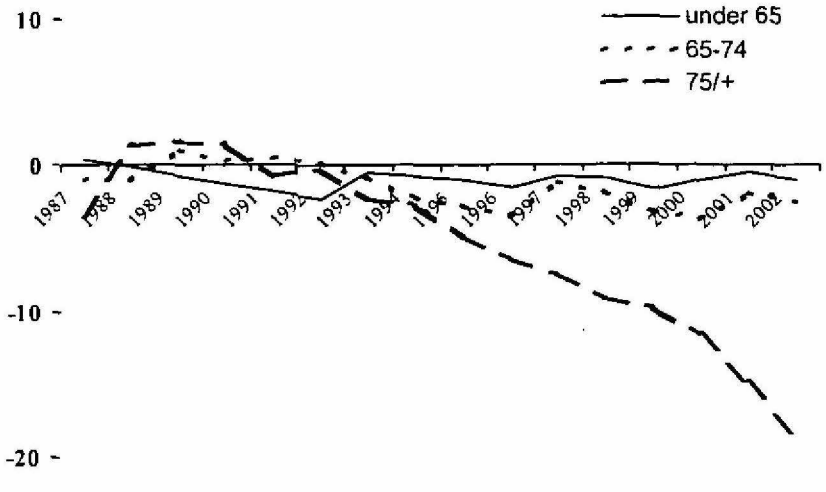
Although Table 6.2 provides some reassurance, a more detailed analysis is required that takes into account the numbers of patients registered with the included general practices. This additional information would enable calculation of the rate of deaths in the three practices, and provide a more meaningful comparison between Code A Code A and other doctors. Information about the numbers of patients registered with each general practitioner was obtained from the Hampshire and Isle of Wight Practitioners and Patient Services. Although the Agency was able to supply information from 1987 onwards about the numbers of patients in three age bands (0-64 years, 65-74 year, and 75 years and over), details on the numbers who were male and female were available only from 1996.

The number of patients registered with a general practitioner is not necessarily an accurate reflection of the number of patients the doctor directly cares for. Within a general practice, some doctors may undertake work outside the practice (as did Code A Code A) and therefore not care for so many patients in the practice. A doctor may

choose to work part-time for other reasons. Therefore, the numbers of patients registered with the doctor were not used in estimating mortality rates. Since detailed information about the work patterns of the general practitioners in the comparison practices was not available, the numbers of patients cared for by each general practitioner was taken to be an equal share of the total practice list size. For example, using this method, in a practice of five doctors and with a total of 10,000 registered patients, the numbers cared for by a single doctor would be assumed to be 2000.

Deaths among males and females combined up to 1995 are shown in Table 6.3 to 6.5, and deaths among males and females separately from 1996 to 2002 are shown in Tables 6.6 to 6.10. Each Table displays the numbers of deaths certified by doctors in the comparison practice, the numbers certified in Code A 's practice (the index practice), and the numbers certified by Code A The Tables also show the numbers of patients registered with the comparison and index practices, and the estimated number under the care of Code A These data are used to calculate the number of certificates that would have been expected to have been certified by Code A Code A based on the comparison practices, and the difference between the expected number and the number she did in fact certify. In all but two of the Tables, the total of the difference between the numbers expected and observed is less than zero. The cumulative difference between the expected and observed numbers of deaths in the three age bands is displayed in Figure 6.1.

Figure 6.1. The cumulative difference between the observed and expected numbers of MCCDs issued by Code A, 1987-2002. (Deaths occurring at home, or in residential or nursing homes).



By 2002, the total difference between the observed and expected certificates issued by Code A was –0.99 for patients aged 0-64, -2.54 for those aged 65 to 74, and -18.53 for those aged 75 and over. These figures provide further reassurance about the care given to patients in general practice.

Table 6.3. Deaths and death rates/1000 patients under the age of 65 1987-1995 (males and females).

year	Patients in control practices	Deaths in control practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Code A's list (estimate)	Certified by Code A	Expected deaths	Observed – expected, Code A
1987	15376	5	8644	10	.33	1.16	1729	1	.57	.43
1988	15457	5	8569	7	.32	.82	1714	0	.55	-.55
1989	15673	5	8665	3	.32	.35	1733	0	.55	-.55
1990	15490	5	8634	7	.32	.81	1727	0	.55	-.55
1991	13192	4	8644	5	.30	.58	1729	0	.52	-.52
1992	13009	4	8578	2	.31	.23	1716	0	.53	-.53
1993	12933	2	8535	4	.15	.47	1707	2	.26	1.74
1994	13055	1	10819	2	.08	.18	1803	0	.14	-.14
1995	13244	2	10745	4	.15	.37	1791	0	.27	-.27
Total observed - expected										-.94

Table 6.4. Deaths and death rates/1000 patients age 65 - 74 1987-1995 (males and females).

year	Patients in control practices	Deaths in control practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Code A s list (estimate)	Certified by Code A Code A	Expected, Code A	Observed – expected, Code A Code A
1987	1271	8	783	6	6.29	7.66	157	0	.98	-.98
1988	1315	8	788	9	6.08	11.42	158	1	.96	0.04
1989	1326	8	788	8	6.03	10.15	158	3	.95	2.05
1990	1331	7	785	7	5.25	8.92	157	0	.82	-.82
1991	1176	14	800	6	11.90	7.50	160	2	1.90	0.10
1992	1144	9	805	6	7.87	7.45	161	1	1.27	-.27
1993	1145	7	779	6	6.11	7.70	156	0	.95	-.95
1994	1157	9	986	2	7.78	2.03	164	0	1.28	-1.28
1995	1147	5	993	8	4.36	8.06	166	0	.72	-.72
Total observed - expected										-2.83

Table 6.5. Deaths and death rates/1000 patients age 75 and above 1987 – 1995 (males and females).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Code A Code A's list (estimate)	Certified by Code A Code A	Expected, Code A	Observed – expected, Code A
1987	1231	38	688	28	30.86	40.70	138	1	4.26	-3.26
1988	1231	31	687	25	25.18	36.39	137	8	3.45	4.55
1989	1234	52	677	31	42.14	45.79	135	6	5.69	0.31
1990	1227	29	667	38	23.63	56.97	133	3	3.14	-.14
1991	1138	46	640	31	40.42	48.44	128	3	5.17	-2.17
1992	1125	23	616	32	20.44	51.95	123	3	2.51	.49
1993	1087	27	622	19	24.84	30.55	124	1	3.08	-2.08
1994	1091	20	753	19	18.33	25.23	126	2	2.31	-.31
1995	1120	28	771	25	25.00	32.43	129	1	3.23	-2.23
Total observed - expected										-4.84

Table 6.10. Deaths and death rates/1000 patients age 75 and above, 1996-2002 (females).

year	Patients in control practices	Deaths in index practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Code A's list (estimate)	Certified by Code A Code A	Expected, Code A	Observed – expected, Code A Code A
1996	752	25	471	9	33.24	19.11	79	2	2.63	-.63
1997	731	17	494	15	23.26	30.36	82	2	1.91	.09
1998	730	15	511	13	20.55	25.44	85	0	1.75	-1.75
1999	742	14	491	11	18.87	22.40	82	2	1.55	.45
2000	736	9	492	8	12.23	16.26	82	0	1.00	-1.00
2001	779	22	505	9	28.24	17.82	84	0	2.37	-2.37
2002	770	24	508	7	31.17	13.78	85	0	2.65	-2.65
Total observed - expected										-7.86

Chapter Seven: Conclusions

In this audit or review, information has been obtained from a variety of sources about the care delivered to patients of the Department of Medicine for Elderly People at Gosport War Memorial Hospital, including death notifications stored by National Statistics, the counterfoils of medical certificates of cause of death, clinical records, controlled drug registers, and ward admissions books. Whilst there are inevitable reservations about the completeness of these sources, when viewed together they enable conclusions to be reached. In this Chapter, the reservations about the data used in the review are summarised, the findings are outlined, and conclusions are presented. Relevant recommendations are also made.

The sources of information

It has not been possible to undertake a comparison of mortality rates between Gosport and other community hospitals because centrally held Hospital Episode Statistics data do have sufficiently detailed provider codes to identify groups of patients similar to those admitted to Gosport. However, whilst such an analysis would be desirable, I would not expect that the findings would significantly alter the conclusions of this review.

The notifications of deaths provided by National Statistics were a reliable source of information about the numbers of deaths certified by Code A and the comparison general practitioners. Therefore, conclusions based on this information can be regarded as safe. It should be noted, however, that notifications would not have included information about cases certified by coroners. The data provided by National Statistics corroborate the numbers of deaths identified from the counterfoils of MCCDS that had been stored at Gosport hospital. Consequently, the findings from

the analysis of the counterfoils can also be regarded as reliable, although the lack of information about cases investigated by the coroner must be noted again.

The data contained in the controlled drugs registers are likely to have been reasonably accurate and complete, although it is not possible to verify this through comparison with another source. The administration of controlled drug registers must be recorded in registers, and the registers at Gosport did appear to have been maintained correctly. Ward admission books are not required to be maintained to such a standard, and the policy on admission books varied in different wards. Only Dryad ward's book was found to be a satisfactory source of information. The admission books are therefore the source of information about which there should be most caution. Nevertheless, significant weaknesses in the information in the books were not detected during the review, and they probably do represent a reasonable record of the admissions of patients to the ward.

Summary of findings

The investigation of a random sample of records indicated that:

- Patients admitted to Gosport hospital were elderly, had severe clinical problems, and had commonly been transferred from acute hospitals after prolonged in-patient stays. Although some were admitted for rehabilitation, most were believed to be unlikely to improve sufficiently to permit discharge to a nursing home.
- Of the 81 patients in the sample, 76 (94%) had received an opiate before death, of whom 72 (89%) had received diamorphine.
- When administered by syringe driver, diamorphine was invariably accompanied by other medication, most commonly hyoscine and midazolam.

- The mean starting dose of diamorphine was greater than would have been expected if the rule of thumb of giving one third of the total daily dose of morphine had been followed.
- Opiates were used for patients with all types of conditions, including strokes, heart conditions, and end stage dementia.
- There was little evidence of the three analgesia steps recommended in palliative care (non-opiate, then weak opiate, then strong opiate).
- Opiates were commonly prescribed on admission, although not administered until some days or even weeks later.
- Some records failed to indicate that an acute deterioration in a patient's condition had been followed by a careful assessment to determine the cause. Opiates may have been administered prematurely in such cases.
- The records commonly did not report detailed assessments of the cause of the patient's pain.
- The pattern of early use of opiate medication was evident from 1988.
- The records did not contain full details of care. Only 48 (59.3%) contained sufficient information to enable a judgement to be made about the appropriateness of care. In 16 of these, I had some concerns about the indications for starting opiates, the investigation of pain, or in the choice of analgesic.
- Code A did not report recent fractures, including fractured hips, on MCCDs. These cases were commonly reported as having died from bronchopneumonia.

The counterfoils of MCCDs stored at Gosport hospital indicated that:

- Code A had issued 854 certificates from 1987.

- The number of certificates was between 30 and 40 per year between 1988 and 1992, when Code A was responsible for patients in Redclyffe Annexe and some in the male and female wards. The numbers increased to between 80 and 107 per year between 1993 and 1999 when Code A became responsible for patients in Daedalus and Dryad wards.
- Code A issued between nil and six MCCDs per week. There were no clear clusters of deaths.
- Code A was more likely than other doctors to give bronchopneumonia with *other conditions or bronchopneumonia only as the cause of death.*

The investigation of Dryad ward's admissions books indicated that:

- Of the 684 patients admitted between 1993 and 2001, 405 (59.2%) died in the ward.
- The mean age of the people admitted was 82.7, and around three quarters had been transferred from an acute hospital.
- There was a change in the patients admitted to the ward from around 1997. After that year, there was an increase in the proportion of patients who had been admitted for respite care, and by 1999, the proportion of patients who died had decreased.
- The proportions of patients who died in each hour of the day were as would normally be expected.

The investigation of controlled drugs registers indicated that:

- Patients in whom the MCCDs had been issued by Code A were more likely to have received an opiate before death.

- The greater use of opiates was found in relation to all causes of death except cancer, although when this analysis was confined to patients in Redclyffe Annexe, there were no significant differences between Code A and other doctors.
- Code A did not prescribe opiates to individual patients for longer periods of time than other doctors.

The investigation of MCCDs indicated that:

- The counterfoils stored at Gosport hospital were an accurate record of the deaths in the hospital.
- There was no evidence that more than the expected number of deaths had been certified by Code A. In fact, the number was less than expected if Code A Code A had undertaken an equal share of the workload in general practice.
- A greater proportion of MCCDs issued by Code A were for female patients, and were more likely to have been certified as dying from heart conditions. These findings are probably incidental and are not reason for concern.

Conclusions

Patients admitted to Gosport were elderly and with severe clinical problems. Most had been transferred from acute hospital settings after a period of intensive management, at the end of which it had been concluded that further intensive management would have little or no benefit. Patients were transferred to Gosport either for rehabilitation or for continuing care (defined by CHI as 'a long period of treatment for patients whose recovery will be limited').

In this group of very ill and dependent patients, a practice of liberal use of opiate medication can be discerned from the findings of the review. Patients who

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. I would also expect that in a smaller number of cases, the practice will be found to have shortened the lives of people who would have had a good chance of surviving to be discharged from hospital.

From the evidence considered in this review, it is not possible to determine how the practice of almost routine use of opiates at Gosport originated. Whilst much of the review has focused on the work of Code A this is because she issued the MCCDs and made most of the entries in the clinical records. However, this should not be taken as meaning that she was the origin of the practice, she may merely have been implementing it. Indeed, the practice may have been introduced before Code A began work in Gosport as a Code A in 1988.

Recommendations

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Code A and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.

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4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to suspect that some patients at the end of life do not receive adequate analgesia.
5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

HAMPSHIRE CONSTABULARY

RECEIVED FROM HAMPSHIRE CONSTABULARY

THREE BOXES CONTAINING FILES AS LISTED

TWO FILES CONTAINING PAPERS/REVIEWS OF THE EXPERTS

Code A

POLICE OFFICERS REPORTS AS ENCLOSED WITHIN THE TWO FILES

SIGNED

FORMAT OF FILE CONTENTS

1. DOCUMENT LISTING THE CONTENTS OF THREE BOXES DELIVERED TO G.M.C 10 09 2004

2 REVIEW OF EXPERTS

A.
B.
C.
D.

Code A

3. POLICE OFFICER'S REPORT

4. CASE REVIEWS BY

Code A

CONTENTS OF BOXES TO G.M.C. 10 09 2004

REF. NAME		FILE CONTENT
BJC/1A	Code A	COPY OF MICROFILM PAPERS
BJC/2		COPY OF MICROFILM PAPERS
BJC/6A		COPIES OF TWO SETS OF MICROFILM PAPERS
BJC/6B		COPY OF PAPER RECORDS
BJC/9		COPIES OF TWO SETS OF PAPER RECORDS
BJC/17		COPIES OF TWO SETS OF PAPER RECORDS AND COPY OF MICROFILM PAPERS
BJC/23		COPY OF PAPER RECORDS AND COPIES OF TWO SETS OF MICROFILM RECORDS
BJC/31		COPIES OF TWO SETS OF PAPER RECORDS
BJC/7		COPIES OF TWO SETS OF PAPER RECORDS
BLC/12		COPY OF PAPER RECORDS

BJC/22 & JR/1	Code A	COPIES OF TWO SETS OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/26		COPY OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/35		COPY OF PAPER RECORDS
BJC/36		COPY OF PAPER RECORDS
BJC/37		COPIES OF TWO SETS OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/38		COPY OF PAPER RECORDS AND COPIES OF TWO MICROFILM PAPERS
BJC/40		COPY OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/42		COPIES OF TWO SETS OF PAPER RECORDS
BJC/47		COPY OF MCROFILM PAPERS

Code A

Code A

Code A

Date of Birth: Code A Age: **77**
Date and time of Death: ***00.05hours on*** Code A
Cause of Death:
Post Mortem: Cremation
Length of Stay: **1 day**

Code A. He had had recent bouts of chest infections, confusion and poor mobility. It was noted that he was a heavy smoker.

Code A was admitted to the Gosport War Memorial Hospital on 29th May 1990 as an emergency, requested by Code A could no longer cope with him at home.

On admission Code A was assessed and his medication was boarded. The foot of his bed was elevated because his ankle and foot were oedematous. During the night Code A became very confused and incontinent of urine. He was given Temazepam 10 mgms at 22.15 hours.

Code A died at 00.05 hours on Code A, his Code A were informed and his death certified by Code A

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification Code A **Exhibit number**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Code A		
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A

Date Of Screening:

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7E

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT:

REF:
TEL/EXT:

SUBJECT: OPERATION ROCHESTER
Code A

DATE: 13/11/2002

On 10th November 2002 (10/11/2002) I visited Code A and Code A Code A at Code A's home address of Code A Code A

They had contacted the Health Authority in relation to the death of Code A who had died GWMH on Code A after seeing media reports on the hospital.

Code A lived at Code A with Code A

He worked as a stevedore for the MOD and is described as being very fit.

He suffered from arthritis and the ..... but was not taking any medication for them. He was a life long smoker and had a chesty cough.

Around April 1990, Code A had a chest infection for which he was prescribed antibiotics. He was visited by Code A, as he was not on a doctors list. The infection left him very weak and unwell but he was not admitted to hospital, he did attend GWMH for an x-ray which confirmed the diagnosis of chest infection.

At this point he was sleeping a great deal and was suffering from hallucinations due to the lack of oxygen getting to his brain. This was directly attributable to the infection and stopped as he began to recover. They are described as 'brief' and 'temporary'.

Code A oversaw his treatment which did not include any pain killers, just the antibiotics.

Throughout this period, Code A remained alert and able minded, he was however left very weak and required help to reach the bathroom. Because of this Code A became very tired and worn down and it was suggested that Code A be admitted to the GWMH mainly for him to regain his strength and as a respite for Code A

Code A didn't wish to be admitted but recognised that his wife needed a rest. He was admitted to a mens surgical ward on the ground floor of the GWMH and 1930 hrs on 30/05/1990 and settled into a chair, the family left him as he was about to taken to the day room to have a cigarette. The staff

informed them that he would 'be made comfortable' and that they could 'come and see him in the morning'.

Around midnight the hospital contacted the family to inform them that Code A had died.

The family are concerned that Code A was given medication that was too strong and as a result he died.

Code A was cremated.

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AX

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 01/12/2003

I attended the home address of Code A at 1000 hrs on Thursday 27th November 2003 (23/11/2003) in relation to Code A, as per the policy log. Also present were Code A Code A

I discussed the nature of the family's initial concerns as per officers report 7E.

They felt that all of the relevant points had been covered and were given a copy of Code A s medical records.

The family is happy to be notified by letter in 'layman's terms' but would like to have the opportunity for a follow up visit if they feel they have questions.

Expert Review

Code A

No. BJC/01A

Date of Birth:

Date of Death: **Code A**

Code A was admitted to the Gosport War Memorial Hospital on 29 May 1990 as an emergency. Code A requested this as Code A could no longer cope with him at home.

On admission he was diagnosed as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission. He was then administered 10mgs Temazepam apparently which had been written up for him.[VA1]

The experts criticised the use of a small dose of Temazepam in a patient who is cyanosed. They note, though, that Code A was already very unwell.

HAMPSHIRE CONSTABULARY

Code A

HAMPSHIRE CONSTABULARY

Code A

Dennis Amey

Date of Birth: Code A Age: **62**
Date of Admission to GWMH: **14th November 1990**
Date and time of Death: ***16.30 hours on*** Code A
Cause of Death:
Post Mortem:
Length of Stay: Code A **days**

Code A past medical history shows that he suffered from:-
Parkinson's disease

Prior to his admission to the Gosport War Memorial Hospital Mr Amey lived at home with Code A. He was admitted on 7th November 1990 for terminal care, he suffered from Parkinson's disease.
Code A requested that Code A was admitted.
Code A had problems with his catheter, he was incontinent and was having spasms and was in pain.
He needed help with feeding and had difficulty with swallowing. He was noted to be irritable by the duty doctor.
He was nursed on a Pegasus mattress and had red sores.
It was noted in the clinical notes that he had pus discharging from his penis and had gangrenous areas around his scrotum and that he needed pain relief.

On 19th December 1990 Code A was written up for **Diamorphine to be administered using a syringe driver**. The dosage was 120mgs over a 24 hours period.
On Code A died at 16.30 hours.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

Code A

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Code A		
Unclear B				
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BD

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 06/12/2003

I attended the home address of Code A, the Code A of Code A at 1000 hrs on Thursday 27th November 2003 (27/11/2003). Also present was Code A Code A The visit was as per the policy log, a set of Code A 's medical records were provided.

I outlined their concerns as per officers report 8C and they felt that they had nothing further to add in relation to Code A however they wished to bring to our attention concerns they have in relation to Code A who currently lives in a warden controlled complex.

Code A has been a diabetic since her late 50's, early 60's. She suffered from Osteoporosis and her diabetes is now insulin driven.

Code A was being treated by her GP, Code A and was being prescribed pain killers.

On one occasion Code A had to see Code A, a partner in Code A 's surgery. Code A Code A said to Code A "Why are you on morphine, you'll end up at ..." and said the name of a local undertakers. He took her off the morphine.

Some years later, around 1999, Code A was suffering from back pain. Code A visited and gave her an injection. She was admitted to the GWMH t o be assessed for her diet and diabetes.

After a couple of days after being admitted Code A is described as being "out of her head", incoherent and slurring her words. Her tongue appeared swollen.

The family removed Code A from hospital and after a couple of days she appeared to be her normal self.

Code A felt that Code A should then have gone into a nursing home and she took Code A off her patient list. Code A now attends the Bridgemary Surgery and is under Code A

They also mentioned their Code A who at the age of 21 yrs had a fall at her flat. She was admitted to the QA where she developed shingles. She was then transferred to the GWMH to recuperate from her illness. She had no injuries from her fall.

Whilst at the GWMH she had a box which went somewhere into her neck, she died shortly afterwards. Whilst at the hospital she suffered from hallucinations, believing that she was in the workhouse.

The family are happy to be notified by letter.

Expert Review

Code A

No. BJC/02

Date of Birth:

Date of Death: **Code A**

Code A was admitted to Gosport War Memorial Hospital on 14 November 1990 following a request from Code A at that time had problems with his catheter, he was incontinent and was having spasms. Code A had very severe Parkinson's disease. He was admitted for terminal care.[DA1]

Code A was started on Morphine elixir on 11 December 1990 and by the time of his death on Code A he was on 120mgs of Diamorphine subcutaneously per twenty-four hours. Code A notes that Code A was very unwell and in pain.

The experts have determined that this dose of Morphine was high and possibly sub optimal but without additional documentary evidence cannot be clear as to whether the doses of Diamorphine was escalated only in response to uncontrolled pain.

HAMPSHIRE CONSTABULARY

Code A

Code A

Code A

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **September 1990**
Date and time of Death: **10.55 hrs on** Code A
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **3 years 3 months**

Code A 's past medical history states that she suffered from:-

1969 – Menieres
1973 – Partial gastrectscomy
1975 - Gastrectomy
1976 – Cervical spondylosis
1981 – Epilepsy
1984 – Prostatectomy benign
1989 – Colostomy – CA descending colon
Parkinson's Disease
History of depression.

Code A lived at home with Code A They had a Code A had CVS disease and felt that she was unable to cope. Code A was admitted to the Gosport War Memorial Hospital in September 1990 for Geriatric long stay and for physio and investigation for his Parkinson's disease. It was noted that as his Parkinson's worsened he was unsteady on his feet and needed a stick and the help of a nurse.

Care Plans for sleep, colostomy, catheter, noting urinary tract infection and retention and mobility noting problem right foot, personal hygiene, epilespy and agitated were completed dated 14th November 1993.
A care plan for commenced on 27th September 1993 for red sacrum.

20th December 1993

Seen by Code A – no change.

28th December 1993

Complaining of generalised pain. Seen by Code A **Oramorph 10mg 6 hourly.**

30th December 1993

Nightmare end of last week disturbed and agitated. Quick and complete recovery.
Appears in pain **Oramorph increased** 10mg 4 hourly and 20mg nocte. ? whether pain is being controlled, difficulty taking oral medication. Discussed with Code A happy to put syringe driver.
11.30 hours syringe driver commenced **Diamorphine 40mgs.**

HAMPSHIRE CONSTABULARY

Code A

31st December 1993

General condition deteriorates. Nursed on side left buttock very red. Red/blackened area noticed. Syringe driver satisfactory. Assisted when patient turned. Twitching at times.

1st January 1994

Unchanged. Nursed on side. Skin marking also on right heel.

Code A

Code A died at 10.55 hours. Next of kin informed. For cremation.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

Code A

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Code A		
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A
Date Of Screening:

Signature

Code A

Code A

Expert Review

Code A

No. BJC/06A

Date of Birth:

Date of Death: **Code A**

Code A was admitted to Gosport War Memorial Hospital in September 1990 for long stay care. He had a previous history of Parkinson's disease, epilepsy and Ménières.

He was treated with Coproxamol regularly for a period of years for pain although its origin was not clear.

In December 1993 he was complaining of generalised pain and started on Oramorph. Code A notes that Code A went from little analgesia to Oramorph 60mgs in twenty-four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment.

The experts review has determined that the treatment was sub optimal due to the high doses, especially Midazolam. Cause of death was felt to be unclear by the expert team.

HAMPSHIRE CONSTABULARY

Code A

Code A

Code A

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **3rd February 1998**
Date and time of Death: Code A
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **19 weeks**

Code A's past medical history:-
Masangio-proliferative glomerulonephritis due to chronic renal failure
Fracture neck of femur
CA prostate
Myeloma diagnosed on bone marrow
Spinal osteoporosis
Artrial fibrillation

Prior to his admission to hospital in February 1998, Code A lived at home with Code A He fell and sustained a fractured neck of femur. Code A Code A had been Code A's main carer as she had also had hip replacements and was not mobile. It was hoped that he would be discharged home with a complete care package or go into residential care. He had deteriorating vision and had cataracts in both eyes. Code A Code A
It was noted in Code A's notes that he was allergic to morphine and was on warfarin.
Prior to his admission Code A had a history of falls. He was a very alert man but slow at times.
He was admitted to Gosport War Memorial Hospital from Queen Alexander for rehabilitation following an operation where a dynamic hip screw was inserted.

A Waterlow score of 25 was recorded on 22nd April 1998 going down to 17.
A Barthel ADL index was completed noting 11 on 18th April 1998 going up to 17 later. The aim was to rehabilitate Code A with a view to him going home with a complete care package.
A nutritional assessment of 3 was recorded on admission.

15th January 1998

Admitted to Hospital after fall where he sustained a fracture to the neck of femur on the right side.

20th January 1998

Operation dynamic hip screw.

3rd February 1998

Transfer to Gosport War Memorial Hospital for rehabilitation. He was nursed in a side room because he tested positive for MRSA. He was nursed on a Pegasus biwave mattress and needed the help of two nurses for transfers.

March 1998

OT assessment.

5th March 1998

Clinical notes state GP contact by nursing staff. Gets **drowsy with small amount of morphine.** Need to be cautious previously been on MST.

6th April 1998

Unsuccessful home visit.

14th May 1998

Sore heels noted. Skin intact.

24th May 1998

Complained of excessive chest pain. Impression musculoskeletal pain.

4th June 1998

No improvement. Chesty very rattly. **For morphine.** Family happy with care and **syringe driver discussed.**

5th June 1998

Higher dose of oramorph given.

9th June 1998

Changed oramorph to MST. Complaining of chest pain.

10th June 1998

Taking MST/oramorph. For syringe driver is pain not adequately controlled.

11th June 1998

Painful back- swallow and appetite poor. Seen by Code A syringe driver commenced. Family informed.

12th June 1998

Deteriorating pronounced dead by S/N Code A at 21.15 hours. Relatives present.

Code A

Death certified. For cremation

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification Code A **Exhibit number**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Code A		
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A
Date Of Screening:

Signature

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R13D

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: FCU FLEET

REF:
TEL/EXT:

SUBJECT:

DATE: 14/02/2003

On Wednesday 29th January 2003 (29/01/2003) I went to the home of Code A concerning the death of Code A

Prior to his death, Code A lived with Code A in Gosport. Sometime before his death Code A was diagnosed with Prostate Cancer. It was caught fairly early and was not deemed to be terminal. He went into Haslar Hospital for chemotherapy treatment in tablet form. This treatment was successful and he was transferred to the Gosport War Memorial Hospital for rehabilitation.

A few weeks before Code A death Code A was approached by staff. They requested that he look for a nursing home for Code A as he could not stay there indefinitely. Code A states that Code A was very alert and vocal. He had made a friend called Code A recalls that the two of them used to complain about the nurses who did not appear to be looking after the older and more frail patients properly.

Code A would often tell Code A that the nurses would just place food in front of patients who were clearly unable to feed themselves then an hour or so later would just take it away again without attempting to help them eat.

Code A recalls a senior nurse named Code A who appeared to be running the ward. He seemed to have a lot of authority and was making decisions that would normally be associated with a doctor.

The evening before Code A death Code A had gone to visit Code A after work. He found Code A Code A in good spirits, talking about the football results. Code A was also there with Code A Code A was asking about Code A homework and asked him to come back tomorrow to tell him about it. At about 7.00pm (1900) the family left. About an hour later Code A received a call from the hospital saying Code A had taken a turn for the worse. He immediately went to the hospital to find Code A unconscious, he noticed that he had been fitted with a syringe driver and was receiving Diamorphine. Code A never regained consciousness and died the next day. As far as Code A was concerned there was no doctor on duty over that period.

The two main questions that the family are seeking answers to are:

What sort of emergency occurred shortly after they left that evening?
Who attended Code A and who authorised that he should be put on such large doses of Diamorphine?

Code A was cremated. The family is represented by Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BA

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 06/12/2003

I visited Code A at 2000 hrs on Tuesday 25th November 2003 (25/11/2003) at his home address, Code A was also present (Code A

The meeting was in relation to their Code A and as per the policy log.

I outlined the concerns as noted in officers report 13D and noted the further comments of Code A Code A as;

At the time of Code A deterioration the family had been searching for a suitable rest home for him to move to.

Code A was in the hospital for rehabilitation after a hip replacement. He had come through six weeks of isolation for a super bug.

Code A wishes to know:

1. Why the family were not consulted prior to the treatment being commenced?
2. Who took the decision and why?
3. Who administered the drug?
4. In what quantity?
5. And what was actually given to Code A ?

The Code A family is happy to be informed by way of a letter, they have been given a copy of the medical records.

Code A was agitated during the meeting but he suffered the loss of Code A three weeks ago from cancer.

Expert Review

Code A

No. BJC/06B

Date of Birth: Code A

Date of Death:

Code A was admitted to hospital on 15 January 1998 after a fall where he sustained a fracture to his neck of femur.

On 3 February 1998 he was transferred to Gosport War Memorial Hospital for rehabilitation. His medical history included carcinoma of the prostate, osteoporosis and myoma.

He was assessed in March 1998 with a view to being discharged home but, following a trial visit on 6 April 1998, this was not considered a possibility.

In May 1998 he developed musculoskeletal chest pain together with a chest infection.

The infection did not respond to antibiotics despite a change in treatment.[DB1]

Opioids were started when Code A s condition was failing on the second antibiotic tried.

The experts note that the Morphine/Diamorphine was escalated and a large amount of Hyoscine and Midazolam added to the syringe driver although it was not felt death was accelerated as a result of this treatment.

HAMPSHIRE CONSTABULARY

Code A

HAMPSHIRE CONSTABULARY

Code A

Code A

Date of Birth: Code A Age: **79**
Date of admission to GWMH: **11th May 1999**
Date and time of Death: Code A
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: Code A **days**

Code A past medical history:-

CCF
Confusion
Hypertension
Register partial sighted
IHD
Varicose veins
Hallucinations

Code A in 1995 and lived alone. He had lived in the same council house for twenty years and had just applied for a flat nearby. He had a Code A who helped with shopping and cleaning but managed without help apart from meals on wheels. Code A also had Code A in Gosport and Code A in Southampton and Havant. Prior to his admission he had started to neglect himself.

Code A had numerous admissions to hospital. In May 1999 he was admitted to the Gosport War Memorial Hospital from the Queen Alexander Hospital for rehabilitation after suffering another CVA, CCF, CXR right plural effision and chest infection.

On admission an assessment and patient profile was completed. A handling evaluation was also completed noting that Code A needed the help of 1 or 2 nurses.

A nursing assessment was completed and several care plans were commenced including hygiene, constipation, transferring and help to settle at night.

A Barthel ADL index was completed ranging from 10-15. A nutritional score of 17 was recorded.

A Waterlow score of 15 and 17 was also recorded.

11th May 1999

Admitted to Gosport War Memorial Hospital from Queen Alexander Hospital where he had been admitted as an emergency by his GP with right CVA, CCF, CXR right pleural effision, possible chest infection. He was admitted onto Dryad Ward for continuing care.

14th May 1999

Complaining of increased pain – feeling unwell.

17th May 1999

Depressed – Seen by Code A – scan at Haslar to be arranged.

21st May 1999

Brain scan – CVA at Haslar.

24th May 1999

Walking unaided.

2nd June 1999

Very confused at times. ? aim for home for trial period three to four days next week. Discuss with family.

7th June 1999

Hallucinating/distressed.

15th June 1999

Catherised – complaining of feeling weak and pain. Had to be fed. Oramorph commenced 5mgs. ? Lewi body disease.

To be discharged to rest home not for home.

16th June 1999

Fentanyl commenced 25mgs plus oramorph 5mgs.

17th June 1999

Slept long periods.

18th June 1999

In a lot of pain on movement. Bowels not open for a few days. Oramorph given. Syringe driver to be considered.

Deteriorating.

19th June 1999

Seen by Code A syringe driver commenced 40mgs diamorphine.

Code A

Deteriorated. Bronchopneumonia on S/C analgesia. Syringe driver (2 drivers) reprimed diamorphine 60mgs.

19.10 hours died. Death confirmed S/N Code A and Nurse Code A

For cremation.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

Code A

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Code A		
Unclear B				
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A
Date Of Screening:

Signature

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AZ

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 02/12/2003

I attended the home address of Code A at 1845 hrs on Monday 1st December 2003 (01/12/2003) as per the policy log in relation to Code A.

I outlined the concerns of his family as per OR71. These were agreed with the added concerns that the family are now aware that diamorphine was administered at the same time as a fentenol patch was being used and that the amount of diamorphine administered was 'not safe'.

The Code A family have a pharmacist and a nurse within their family and both parties have had access to Code A copy of Code A medical records. I provided him with a copy of our records.

The Code A family would like a letter detailing the clinical teams findings with a 'follow up' visit to enable them to ask any questions. They suggest that provision is made for some form of counselling for those who require it at the time of notification.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7I

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: OPERATION ROCHESTER

REF:
TEL/EXT:

SUBJECT: Code A

DATE: 09/12/2002

At 1000 on 31st October 2002 (31/10/2002) I visited Code A Code A in relation to Code A

Code A will say that Code A had been an artillery man in the army, upon leaving he became a builder and pipe layer. It was whilst he was in the building trade that he was involved in an accident and lost the sight in one eye. He was registered disabled by virtue of his partial sightedness and issued a green card.

He then went on to work for British Rail as a porter and finally became a bus conductor up until his retirement.

He was initially married to Code A and Code A some years later. He subsequently Code A who died around 1996 at Haslar Hospital.

Code A lived alone at Code A

He was mobile although suffered from water retention on his ankles and was in full control of his faculties. He had daily callers and used the services of meals on wheels.

Around three months prior to his death, (approximately April 1999) Code A was found at his home address collapsed.

He was taken to the Queen Alexandra Hospital, Cosham, where it was discovered that he was suffering from a kidney infection. He remained at the QA for a couple of weeks before being discharged to the GWMH, Dryad Ward for rehabilitation prior to being sent home.

At this point he is described as being mobile, cheerful and fully alert. He had been successfully treated at the QA and it was felt that he required a little more support at home and arrangements were made for Code A Code A to visit three prospective accommodation. He was not in any pain nor was he receiving any painkillers. He is described as being quite capable of complaining if he was in any discomfort.

Two days prior to his discharge date Code A was informed by a member of staff that that his Code A was in pain, Code A was in bed and he informed Code A that he had to stay in bed and that

he was having injections.

Code A spoke with staff who informed him that Code A was suffering from headaches and was being given painkillers.

From this moment Code A didn't get out of bed again. He was still compos mentus and looking forward to going home.

His condition deteriorated over the cause of the week and Code A was spoken to by a senior nurse and the duty consultant. He was informed that Code A was extremely ill, his vital organs were failing and that they were not sure how long he would live. He was being administered Diamorphine.

Code A found that Code A had been moved to a single room. He could not feed himself or take fluids. He was catheritorised. He was lying in the foetal position. His eyes were closed and he was breathing noisily through his mouth. Code A remained in this condition for about a week.

Code A states that on the day Code A died, he was sick. He describes the vomit like thick black tar.

His concerns over Code A death are that two days prior to his release Code A was suffering from headaches and within two weeks he was dead.

Code A died on Code A His cause of death is given as Bronchopneumonia and the Dr who certified his death was Code A BM .

Code A

Expert Review

Code A

No. BJC/09

Date of Birth:

Date of Death: **Code A**

Code A was admitted in May 1999 to the Gosport War Memorial Hospital from the Queen Alexander Hospital for rehabilitation after suffering a cerebrovascular accident as well as being treated for congestive cardiac failure and a chest infection.

In early June 1999, Code A condition deteriorated and he complained of a pain in his hands and also abdominal pain. Soon after this he was commenced on Fentanyl together with Oramorph and on 19 June, having been seen by Code A Code A, a syringe driver was commenced.

The experts felt that cause of death was probably unclear and noted the opioids were escalated without trying other ways of stopping the pain but did not feel the treatment was negligent.

IMPEGA
Budget

1 495 005

HAMPSHIRE CONSTABULARY

Code A

Code A

Code A

Date of Birth: Code A Age: **85**
Date of Admission to GWMH: **28th December 1998**
Date and time of Death: Code A
Cause of Death:
Post Mortem:
Length of stay: Code A **days**

Code A past medical history:

1955 – Cervical polyp
1980 – Loss of vision left eye, sub-retinal haemorrhage
1987 – left colles fracture
1996 – AF – digoxin
1999 - Cognitive impairment confirmed dementia.
1999 – CVA
2001 – Chest Infection
2001 – August – CVA
2001 – CVA with persistent dysphagia – insertion of PEG tube

Code A was the youngest of six brothers. He was a retired taxi driver. His Code A died in 1993 they had Code A and had Code A and Code A lived at Code A Residential Home. He wore a hearing aid in his left ear and glasses. It was noted that he smoked 2/3 cigarettes a day and was reluctant to eat. He was dependent on nursing staff for all hygiene needs and could only walk a few steps at a time. Code A was admitted to the Haslar Hospital from the home with pneumonia. It was noted that while at Haslar Hospital Code A was nursed on a bed with a pressure relieving mattress and cot sides and that he had some red marks in places that were dry but unbroken. Code A was admitted to the Gosport War Memorial Hospital on 28th December 1998 with pneumonia that had been treated with IV and oral antibiotics, confusion, doubly incontinent and urinary tract infection. It was also noted that he had a catheter insitu.

On admission a Barthel ADL index was completed from 29th December 1998 scoring 2 to 14th May 1999 also scoring 2 the scores reached no higher that 4. An abbreviated mental study was completed on 29th December 1998 with a score of 3 recorded.

A Waterlow score of 14 was recorded on 29th December 1998. With a handling profile also completed on that day noting that Code A skin was intact need a pressure relieving cushion and 2 nurses and a hoist to help transfer.
Care plans for confusion, reduce mobility, retention of urine – catheterised size 12 and help to settle at night were completed starting on 29th December 1998.

Whilst at Gosport War Memorial Hospital Code A had a number of falls where he only sustained minor cuts and bruising. Treatment was administered and he was helped back to bed.

28th December 1998

Admitted from Haslar with pneumonia that had been treated with IV and oral antibiotics, confusion, he was doubly incontinent and had a urinary tract infection and had been catheterised.

4th January 1999

Remains poorly not eating or drinking well. Please make comfortable.
Happy for nursing staff to confirm death.

11th January 1999

Daedalus ward/NHS continuing care. Barthel 4/20 – reluctant to do much not eating or drinking. Prefers to be in bed. Plan:- to give up Pier House for Nursing Home if stable in early February 1999.

15th January 1999

Contact record – found on floor in lounge PM, examined small grazes on left hand – reassured and put to bed. Code A informed.

17th January 1999

Contact record - found on floor in lounge- no apparent injury. Behaviour very irrational PM.

18th January 1999

Did not wake up this morning, stiff unrousable, not in pain – please make comfortable. **Happy for nursing staff to confirm death.**
Contact record – reviewed by Code A Extremely sleepy. Family wish Code A to be made more comfortable.

19th January 1999

Remains poorly – unresponsive. Family aware – no active treatment required not for any fluid replace. Use S/C analgesia if necessary.

20th January 1999

Catheterisation due to urinary retention.

22nd January 1999

Contact record – Code A got off commode and sat on floor. Accident form completed.

25th January 1999

Spent a lot of time in bed. Can transfer unaided. Barthel 3/20 – aggression short lived.

Code A seen – aware very unwell and may not survive. Agreed not for NG feeds, not for antibiotic if pyrexial and NHS continuing care until early March 1999.

Contact record – seen by Code A seen and is aware of prognosis in event of change of condition or chest infection to be kept comfortable.

8th February 1999

Small black spot on left heel.

15th February 1999

A bit better – eating more. Barthel 1-2/20.

1st March 1999

Not drinking much. Barthel 1/20 – no new medical problems. Heels vulnerable.

2nd March 1999

Contact record – found on floor by chair, cut to upper lip, contusion to left eye.

3rd March 1999

Podiatry – left 1st lat side toe red and inflammed.

5th March 1999

Podiatry – sat in chair. Right 2nd toe red medical side. Left 1st still red.

8th March 1999

Fall – left perior? Bruising + upper limb. Barthel 2/20. Review end of month.

9th March 1999

Contact record – seen by Code A – no change.

10th March 1999

Podiatry – left 1st much improved virtually healed. Right 2nd also improved.

13th March 1999

Contact record – found on floor by side of bed. Checked for injuries.

15th March 1999

No great change. Barthel 2/20.

16th March 1999

Contact record – fell to floor in lounge. Abrasion right eye. Accident form completed.

18th March 1999

Contact record – bruising also noted on right side hip.

20th March 1999

Not so well – in pain when being moved in bed. Generalised twitching and *distressed.*

Code A

Marked deterioration over weekend. Family happy with treatment. Died at 22.00 hours found by S/N Code A Death confirmed at 23.10 hours by SSN Code A

Contact record – 22.00 hours found in bed dead. Code A informed does not want to see.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification Code A **Exhibit number**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Code A		
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A
Date Of Screening:

Signature

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BP

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 21/01/2004

I visited Code A at her home address at 2000 hrs, 21st November 2003 (21/11/2003). Also present was Code A I outlined the purpose of my visit as per the policy log and gave the family a set of the medical records relating to Code A Code A

I went through the family's concerns as recorded in officers report 11E.

They further wished to add that whilst Code A was in Haslar Hospital he had been 'picky' with is food, this was normal. He hadn't complained of being in any pain but then he probably would not have mentioned it and that whilst he was moody, he was lucid and talking and was able to walk with the aid of a stick. He had never suffered from ill health apart from having a small hernia.

The family state that Code A was admitted to the GWMH for recuperation in order to get his strength back.

Upon admission he is described as being in good spirits with no complaints of pain. The family members between them visited him daily.

Approximately two weeks after being admitted the family were told that Code A had suffered a massive stroke, the following day they were informed that he was 'getting better', then they were told that he was 'failing'.

When the family turned up to visit Code A on his birthday he was sat up in bed awaiting his presents. They describe him as being 'perky and happy'. They describe his condition as being variable. When he was in bed with his eyes closed he appeared to be asleep on other occasions he would appear to be 'awake' and chirpy with his eyes open.

Code A was placed in his own room and during the last couple of days of his life he was placed on a syringe driver and diamorphine was administered. The family were not told why, nor did they see a doctor.

At this point Code A was bed bound.

On the day of his death Code A didn't wake up. The family stayed with him until 2200. They left to travel to their nearby homes and a few minutes after arriving were notified by the hospital that Code A Code A had died.

The family wish to be notified by letter followed by a visit to provide more detail if required.

DOCUMENT RECORD PRINT

Officer's Report

Number: R11E

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 18/12/2002

Sir

Re. Action 205.

I visited Code A of Code A on Tuesday, 17th December 2002 (17/12/2002). Code A has given her contact numbers as Code A and W. Code A stated that she had contacted the police regarding the death of Code A Code A at the Gosport War Memorial Hospital in 1999 after hearing of the investigation in the media. She also stated that Code A of Code A had attended a meeting at Whiteley, Fareham along with other concerned relatives.

Code A gave the circumstances as follows. Code A was a retired painter and decorator living in Code A Residential Home, Lee on Solent. His GP was from the Lee on Solent Practice in Manor Way, Lee on Solent. Code A was admitted to the Royal Navy Hospital Haslar around the 14th December 1998 (14/12/1998) suffering with a chest infection. Code A was transferred to Daedelus Ward at the Gosport War Memorial Hospital about two weeks later for recuperation. At this time Code A appeared to be making a full recovery.

Within a few days Code A appeared to be heavily sedated and did not recognise his relatives during visits. Code A is not aware what medication if any Code A had been administered but cannot remember seeing any drips until the last few days of his life. Code A did question staff at the hospital as to why Code A was so sedated and was told words to the effect of, "Oh, he is just not so good today." During the first few weeks at the Gosport War Memorial Hospital relatives noticed that although heavily sedated he would often be sat in a chair, but after this he was always just lying in bed.

On the Code A died, the cause of death was given as Bronchial Pneumonia and the death certificate was signed by Code A was cremated.

Code A and the rest of the family thought the circumstances of Code A s death strange but had absolute trust and confidence in the hospital. It was not until the media coverage that they doubted the hospital and came forward.

I have informed Code A that this is an on going and probably long term investigation and I gave

her a contact number for Operation Rochester at Hulse Road.

Code A

Expert Review

Code A

No. BJC/17

Date of Birth: Code A

Date of Birth:

Code A was admitted to the Gosport War Memorial Hospital on 28 December 1998. On admission he was doubly incontinent with a urinary tract infection and had a indwelling catheter.

It is recorded in the Medical Notes that he had a number of falls where he only sustained minor cuts and bruising whilst at Gosport War Memorial Hospital.

The Notes recall on 4 January 1999 that he remained poorly and was not eating or drinking well.

The expert review notes that Code A was deteriorating gradually following admission and then rapidly over the weekend of 20/21 March 1999.

Although there is no record available in the medication cards or in the medical notes one nursing record states that subcutaneous analgesia and Midazolam was started on 20 March 1999.

The experts conclude the care on the ward was reasonable and that it was likely that Code A would have died no matter how well he was cared for.

HAMPSHIRE CONSTABULARY

Code A

Code A

Code A

Date of Birth: Code A Age: **89**
Date of admission to GWMH: **5th July 1993**
Date and time of Death: Code A
Cause of Death:
Post Mortem:
Length of Stay: Code A **days**

Code A 's past medical history:-
Peripheral vascular disease
Non insulin dependent diabetic
Iron deficiency anemia

Code A in their own home. They had a Code A and received good help form their neighbours. Code A was finding it increasingly difficult to cope.
Code A was admitted to the Royal Haslar Hospital where he underwent a sigmoid colectomy and colostomy following diverticullitis and a gangerous gall bladder. He was transferred from Haslar Hospital to Gosport War Memorial Hospital on 5th July 1993 for nursing care and assessment.

Care plan were commenced on 5th July 1993 for a blackened area to left heel, 7th July 1993 right elbow red and flaky, sacrum red and dry, 10th July 1993 sacrum slightly red, 14th July 1993 hygiene, poor mobility, vomiting, urinary incontinence, settle at night and colostomy.
An assessment of daily living was completed noting that Code A had some shortness of breath on exertion, needed a diabetic diet, colostomy satisfactory, mobilises short distances with Zimmer frame.
A Waterlow score of 21 was recorded on 5th July 1993 and one of 22 was recorded on 29th July 1993.

5th July 1993

Admitted to Sultan ward from Haslar for nursing care and assessment.
Sigmoid colectomy and colostomy five weeks ago following diverticullitis and gangerenous gall bladder. Readmitted to Haslar one week ago Code A could not cope, appetite down, colostomy working ok.
Nursing report – admitted from Haslar refer to Social Worker.

10th July 1993

Clinical notes state vomited x 3 brown fluid.
Nursing report – vomited x3 complaining of pain in abdomen. Fainted at lunchtime when stood up.
15.10 hours fall getting off commode. Accident form completed.

13th July 1993

Clinical notes state waiting physio and OT assessments. Abdomen soft.

14th July 1993

Clinical notes state Code A was in renal failure.

15th July 1993

Clinical notes discussion Code A re poor prognosis.
Nursing report – seen by Code A who has spoken with Code A and patient re poor prognosis. Boarded for diamorphine 2.5mg-5mgs IM 4 hourly.

19th July 1993

Clinical notes state slightly better – pain at night from left foot. Morphine 5-10mg 4 hourly as required.
Nursing report – seen by Code A boarded for oramorph 5-10mgs 4 hourly for neck pain.

22nd July 1993

Clinical notes state low R and diet. Continues to vomit. Sleeping better.

23rd July 1993

Nursing report – seen by physio wound treatment to heel discussed.

28th July 1993

Clinical notes state has necrotic heel – gradually improving.
Nursing report – referred to Code A for long term care.

29th July 1993

Nursing report – seen by Code A to be transferred to Daedulus ward.
Transferred to Daedulus Ward.
Clinical notes state seen by Code A Daedulus ward – renal failure much better. Diuretics stopped. Heel ulcer – black, sacrum red and vulnerable, confused. Suggest oral fluids and oramorph.

2nd August 1993

Clinical notes state black heel – 2" diameter, offensive, surrounding heel very red. Barthel 5. Encouraged fluids and oramorph if required.
Nursing report, seen by Code A dressing to heel changed.

5th August 1993

Clinical notes state further deterioration needs analgesia and chat with Code A
Nursing report – condition deteriorating. Commenced on oramorph patient comfortable and appears pain free. Turned 2 hourly day and night.

Code A

Nursing report – visited by wife at 10.30 hours fully aware of poor prognosis.
Died peacefully 11.25hours certified by Code A contacted and Code A informed.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

Code A

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Code A		
Unclear B				
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A

Date Of Screening:

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7A

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT, E

REF:
TEL/EXT:

SUBJECT: Code A

DATE: 28/10/2002

Sir,
I visited Code A at her home address, Code A in response to her letter dated 16/10/2002. This concerned her Code A (details above) and the time he spent at the GWMH.
Code A will say that Code A was a fit and active man. He had been a gunner in the Royal Artillary before leaving to become a diver's assistant and subsequently a publican.
He had undergone surgery for poor circulation in his foot around 1978, whereby he had a new vein inserted into his leg. He suffered no further problems with his leg but was diagnosed as a 'late onset diabetic'
Code A was admitted to Royal Hospital Haslar some time around May/June1993. This was due to him feeling unwell and being sick. He was diagnosed as suffering from a ruptured gall bladder, he underwent surgery for the removal of his gall bladder and the fitting of a colostomy bag.
Code A made a full recovery and was discharged from Haslar some three weeks later to the care of his family.
He then returned home (Code A) be cared or by Code A b.
Code A
At this point in time Code A was up and dressed every day, he never remain in bed and was recouperating well,however, Code A had suffered as a result of all the stress and worry of his illness and his operation and it was suggested by the district nurse that Code A be admitted to the GWMH,in order for Code A to have some respite.
Code A was initially put into a ward on the first floor, Code A cannot recall the ward name.
She states that Code A was up and dressed every day, he never remained in bed. He was unhappy with the fact that he had to return to hospital when there was nothing wrong with him. He was eating normally and generally moaning and being grumpy with the staff. He spent his time listening to music and studying the racing form in his daily paper. He was in full use of all his facualties.
At this time he had a small bed sore on the heel of his foot but this did not cause him any real discomfort and to her knowlage he didn't require any special treatment for it.
Code A states that had Code A been in pain then he would have moaned about it and everyone would have been aware of it.
Approximatly a week later, Code A was moved to Dryad Ward on the ground floor so that he could access the garden area.
Code A belived that Code A was being moved so that he could receive some rehabilitation type care. She states that when he was admitted to the ward, he was dressed and fully mobile.

DOCUMENT RECORD PRINT

Code A has given the following information in relation to the last week of Code A life.
Sunday 1st August 1993 (01/08/1993). Code A visited Code A he was sat in the day room listening to music on the radio, he was fully clothed in his suit. He told her that he didn't like it in the new ward and that he'd been dreaming about rabbits.
Code A spoke to a nurse about Code A because she thought that he had not been taking his diabetic medication. The nurse informed her that Code A had 'kidney problems' and this was the reason for him appearing strange.
On Code A 's next visit she was called in to the nurses office and asked if they could put Code A Code A on Morphine, when she asked why she was told that it would make him more comfortable. She states that she was told that Code A had said that she wanted him on Morphine.
Code A refused to give her consent and suggested that they ask Code A who was his legal next of kin. At the time of this visit Code A was up, dressed and appeared well.
Code A states that Code A never complained to her or Code A of any pain.
Thursday 5th August 1993 (05/08/1993)
Code A visited Code A was in bed and was able to have a normal conversation with them. She did not notice any sort of apparatus around Code A which could have been used for administering drugs.
Code A
Code A was visited around 0900/1000 hrs by Code A and a neighbour. He was described as sleeping peacefully.
Around midday, the hospital contacted Code A to inform her that Code A had died.
Monday 9th August 1993 (09/08/1993)
Code A took Code A to the GWMH in order to collect Code A belongings and his death certificate.
They were concerned and distressed to see that the cause of death had been given as Bronchopneumonia and Senile Dementia. The certificate was certified by Code A
Code A states that Code A never displayed any symptoms of dementia nor was it ever discussed with her family whilst he was in hospital.
She was also concerned that there was nothing that related to Code A 'kidney problem'.
She states that her family didn't want to query the certificate because Code A was extremely upset and as she said 'it wouldn't bring him back'
Code A was cremated in accordance with his long held wishes, there was no post mortem.
Code A 's GP was Code A Stakes Rd Surgery, Gosport.

Expert Review

Code A

No. BJC/23

Date of Birth:

Date of Death: Code A

Code A was admitted to Gosport War Memorial Hospital on 5 July 1993 after he had undergone a sigmoid colectomy and colostomy following diverticulitis and a gangrenous gall bladder.

On admission, in addition to the rehabilitation issues following his abdominal surgery, he was suffering pain in his left foot which was associated with vascular disease.

He was started in August on oral Morphine which was converted to Diamorphine via a syringe driver on 5 August 1993.

The experts note that although he undoubtedly had severe underlying disease the acceleration from one dose of Oramorph to 40mgs of Diamorphine was sub optimal treatment.

HAMPSHIRE CONSTABULARY

Code A

Code A

Code A

Date of Birth: Code A Age: **92**
Date of admission to GWMH: **14th April 1998**
Date and time of Death: Code A
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: Code A **days**

Code A s past medical history:-
1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

Code A lived at Code A Residential Home. She had a Code A and Code A It was noted that she had poor mobility and was confused at times. Code A sustained a fractured neck of femur at Code A on 2nd April 1998 and was admitted to Haslar Hospital for surgery to correct the fracture. She was then admitted to Gosport War Memorial Hospital on 14th April 1998 for continuing care.

On admission a Waterlow score of 30 was recorded with another score of 29 recorded on 8th May 1998
A nutritional assessment plan was completed on 15th April 1998 with a score of 4.
Barthel ADL index was recorded on 14th April 1998 scoring 0, another on 25th April 1998 scoring 1 and another one on 9th May 1998 scoring 4
A handling profile was completed on 16th April 1998 noting that Mrs Lee needed the assistance of 2 and a hoist for transfers.
A mouth assessment was completed on 15th April 1998.
Care plans commenced on 14th April 1998 for MRSA screening, 15th April 1998 for sleep, 16th April 1998 for hygiene, nutrition, constipation and on 26th April 1998 for small laceration right elbow.

14th April 1998

Clinical notes – transferred to Dryad Ward from Haslar for continuing care. Barthel 0. Make comfortable, **happy for nursing staff to confirm death**. It was noted that Code A has sustained a right fracture neck of femur and had undergone surgery of canulating screws on 3rd April 1998. It noted that Code A Code A had poor mobiltiy needed the assistance of 2 nurses, was confused at times, needed full assistance with eating and drinkng due to poor eye sight and that she had a poor appetite. She needed all care for hygiene and dressing and her pressure area were intact and that she needed nursing on a pressure relieving mattress.

Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

Summary – restless, confused. Oramorph 5mg 4 hourly.

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

Clinical notes – MRSA negative. Bottom slightly sore. Start gentle mobilisation will not be suitable for Addenbrookes. Seen by Code A has severe dementia.

24th April 1998

Summary – fell while attempting to get up from commode. Sustained skin flat to right elbow. Accident form completed. Code A informed.

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge.

Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

Summary – seen by Code A re pain oramorph increased to 10mgs 4 hourly (20 mgs nocte).

18th May 1998

Clinical notes – increasingly uncomfortable when I called much better on oramorph.

20th May 1998

Summary – visited by Code A For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**

Summary – restless, agitated. Seen by Code A Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

22nd May 1998

Summary – grimacing when turned. Syringe driver renewed at 09.30 diamorphine 20mgs and midazolam 40mgs. Continues to mark, position changed every couple of hours.

23rd May 1998

Summary – syringe driver recharged at 7.35. 20mgs diamorphine 40mgs midazolam. Position changed every 2 hours.

25th May 1998

Summary – further deterioration. Syringe driver renewed at 07.00 in some distress when being turned. Syringe driver renewed at 14.55 diamorphine 40mgs.

Code A

Clinical notes – died peacefully at 14.45.

Death verified by SR Code A and SN Code A

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification **Exhibit number**

Code A

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B				
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A
Date Of Screening:

Signature

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R11

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 12/11/2002

Sir
Re Action 193. I have spoken to Code A of 24 Code A Code A states that her Code A 92 years Code A died at the Gosport War Memorial Hospital on Code A Code A
The circumstances are as follows:
Code A was a very lively elderly lady who was suffering from senile dementia, apart from this she was a very healthy lady who had not visited her GP for many years and enjoyed an active life, walking for miles a day. Code A was being cared for at home by her family and at the beginning of May 1998 the family were offered the chance of respite care to give them a break. Code A was placed at Addenbrook for a period of care but on the first night fell three times and broke her hip. The family were unable to ascertain whether Code A had actually got out of bed and fallen or had fallen out of bed.
Code A was transferred to the Royal Naval Haslar Hospital where key hole surgery was performed on her hip. She remained at Haslar for 5 days during which time her family describe her as being as bright as a button including the day of the operation almost immediately after she came round from the anaesthetic.
After 5 days she was transferred to Dryad Ward at the Gosport War Memorial Hospital where she was immediately always sleepy. By three days Code A was never placed in a chair and remained in bed asleep. The family queried what the staff were doing to get her walking again but were told that she was in pain and required Morphine which was administered by way of a syringe driver. Whenever Code A visited Code A she was asleep and was told just to sit by the bed and hold her hand stating that Code A would know that she was there. On one occasion Code A visited during which time Code A was distressed and waving her hands about. This upset the Code A who told Code A that she would rather not visit again. This was the only time that any member of the family had seen Code A do anything other than sleep.
On Code A died, the death certificate was signed by Code A giving the cause as Bronchial Pneumonia.
Code A 's GP was Code A of the Forton Road Surgery one of the other partners was Code A Code A
I have explained to Code A that Operation Rochester is an ongoing enquiry into the events at the Gosport War Memorial Hospital and that there would not be any immediate answers to her query. Code A Code A is happy with this action and has been given a contact number for Operation Rochester.

Expert Review

Code A

No. BJC/31

Date of Birth:

Date of Death: Code A

Code A was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Haslar Hospital where she had been admitted for surgery to repair a fractured neck of femur.

On admission, it was noted that Code A had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing.

On admission she was settled on the ward and given oral Morphine.

This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May.

She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam.

The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.

HAMPSHIRE CONSTABULARY

Code A

Code A

Code A

Date of Birth: Code A Age: **65**
Date of Admission to GWMH: **26th April 1999**
Date and time of Death: Code A
Cause of Death:
Post Mortem:
Length of Stay: Code A **day**

Code A 's past medical history states that he suffered from:-

Left hemiplegia secondary to CVA
Angina
Obese
Hypertension
Cardiac failure
Non insulin dependent diabetic (tablet controlled)
Prostatic hypertrophy depression.

Code A was Code A They had Code A Code A was more or less housebound and had been for sometime. Code A was transferred to Daedalus Ward after suffering a CVA. He had undergone a CT scan which showed a right parietal infarct and an old infarct. His speech was slurred and he transferred using a hoist. He was eating and drinking with assistance.

A handling evaluation was completed noting a pressure relieving mattress was in place and his skin intact. It was noted that Code A needed 2 nurses and a hoist for transfers.

On 26th April 1999 a Barthel ADL index was completed and scored 1, a Waterlow score of 23 was recorded noting Code A to be at very high risk of developing pressure sores. A nutritional assessment was also completed with a score of 15 recorded.

Numerous care plans were started on 26th April 1999 including personal hygiene, constipation due to mobility, swallowing, left shoulder pain, pressure sore noting Waterlow score, air mattress pressure relieving cushion and no pressure noted but unable to move to observe all areas, dysplasia, incontinent catheter insitu and assistance to sleep.

26th April 1999

Admitted to Gosport War Memorial Hospital. Daedalus ward for rehabilitation.

Clinical notes state more than happy for nursing staff to confirm death.

Code A

Contact record states Code A is very agitated when family left, unable to get to swallow. Referred to speech and language therapist.
Breath very shallow – colour poor.
Code A contacted and will attend. Seen by Code A and family spoken to.
Cyanosed and clammy. Code A thinks he will not survive.
Dr said **"I will make him comfortable".**
Subcutaneous analgesia commenced.

Clinical notes state further deterioration this AM. Further extension of CVA.
Code A with him and aware. I will make more comfortable.
Code A died at 13.00 hours. Family present.
Code A confirmed by S/N Code A and S/N Code A
Family distraught and distressed.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification Code A **Exhibit number**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		Code A		
Unclear B				
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A

Date Of Screening:

Code A

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R8J

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 20/11/2002

Sir,

With regard to Actions 216, 217 & 203 I spoke with Code A and her Code A Code A and Code A in respect of the death of Code A DOD Code A

Code A joined the Royal Navy aged 13 and served for about 12 years. He left the Navy and joined the MOD as a driver. He Code A Code A in 1957 and had Code A He was medically retired aged 58 suffering from diabetics and high blood pressure.

On about the 13/04/1999 Code A suffered a stroke and was taken to Haslar Hospital . The stroke affected the left hand side of his body and Code A required help with eating and drinking. He was however quite conversant and seemed happy and pain free. On the 26/04/1999 Code A was transferred to the GWMH he arrived at about midday.

Code A was in a small ward by Code A and Code A during the afternoon. He seemed well and asked Code A to place a bet on a horse. Code A was concerned that Code A medical notes had not arrived and informed staff that Code A was a diabetic and needed assistance with eating and drinking. She left with Code A at about 1645 on the 26/04/1999.

Code A was visited at about 1800 hours by his Code A and also by his Code A He had been moved to a single room and seemed "a bit out of it." On the 27/04/1999 Code A was unable to talk and was seen by Code A The family disagree with the medical notes they have seen, in that Code A states she informed them he might die. They also note that the drug chart shows that diamorphine commenced at 1215 hours on the 26/04/1999 whereas the start date for this particular drug was shown as the 27/04/1999.

Cause of death was shown as Cerebrovascular accident (stroke) and was certified by Code A There was no PM and Code A was cremated.

Code A

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AW

TO:
STN/DEPT:

REF:

FROM: Code A
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 26/11/2003

I visited Code A at her home address at 1245 hrs Wednesday 26th November 2003 (26/11/2003). Also present were Code A and Code A The visit was in accordance with the policy log.

I gave Code A a copy of the medical records relating to Code A 27/04/1999 and I went through the concerns as noted in officers report 8J. The family wished the following points to be noted.

That upon his admission to the GWMH , the family told the nursing staff about their Code A needs, these being, his blood pressure tablets, he required a diabetic diet, due to problems after his stroke, required a beaker to drink with, pureed food, feeding and help with his drinking. This information was given to Code A

Code A was then settled into bed (which had joists above) where he studied the racing form.

A family member asked for a drink for Code A which was given in a cup (not a beaker) the family got a beaker.

The family commented on S.N. Code A. They didn't like her manner, they formed the impression that she didn't like the size of Code A who was a 'big man'.

They state that Code A 's drinks were left where he couldn't reach them.

They state that Code A was in good spirits, he was laughing and joking and lucid.

The family made a point of telling Code A that they were to be informed of any change in Code A Code A 's condition. Code A showed the note made in Code A 's records on pg 38.

They stated that the point in the original O/R stating that at 1800 hrs on 26/04/1999 when Code A visited, Code A was still in the main ward at this time but had been moved to his own room later that evening when a family member called Code A visited. At this point he is described as being tired and mumbly but still lucid and could recognise his family.

DOCUMENT RECORD PRINT

That at 1000 27/04/1999 they received a call from Code A telling them to come straight away to the hospital.

When the family arrived Code A was totally unconscious and they were informed that he had taken 'a turn for the worse in the early hours'. The family want to know why they were not called straight away, at the time, as per request as page 38.

The family state they had to wait to see Code A who was 1½ hrs late. They state that Code A Code A told them that Code A had suffered another stroke.

The family then sat with Code A who was lying in bed on his back, propped up and leaning to the right. The sides of the bed were up to prevent him rolling out.

His breathing sounded phlegmy so they propped him further to ease his airway. At this point they saw a tube in the area of his shoulder blades. They describe the tube as 'thin' and there were sticking plaster marks in the same area.

Code A enquired if she should contact Code A at this time and was told that there was plenty of time and to wait for the Dr to visit.

At this point Code A is described as being unable to open his eyes or speak. He moaned or grumbled when moved and his breathing became worse. He was able to squeeze Code A Code A s hand.

The family notified other family members and then Code A arrived.

Code A asked Code A if Code A was going to die and was told "You've got to let nature take its course".

The family then asked Code A exactly what was happening and they asked if Code A was squeezing their hands because he was in pain. Code A then examined Code A and said that she could give him something to make him comfortable.

The family left the room whilst nurses attended to Code A. When they returned he was propped up in bed with a fan directed on him, he was cold and turning blue so the family turned the fan off and covered him up.

Approximately 10 minutes later Code A died.

The family further wish to mention the following:

When did Code A begin to deteriorate as he died so quickly between 1000.

When he had his stroke at home he was able to walk to the ambulance.

Why was he not removed back to Haslar when he suffered the second stroke.

On page 70 he was asking for a drink am 27/4 to not responding at all (entry S.N. Code A

On page 68 there is no pressure sores, Code A would have to have been moved in order for them to have been seen.

On page 60 Code A is sat out in chair early am, after having a blanket bath, the family were with him since 10000 how early is early?

On page 64 he was given fluids and referred to speech and language therapist, this is on the day he died.

On page 72 (27/04/1999) his urine is described as concentrated, the family described him as drinking a lot normally.

On page 48 (27/04/1999) Code A has made an entry ref sub fluids. This was not in place when the family attended on 27/4 and it is not indicated or referred to in the nursing notes.

All of the above entries were made in the medical notes prior to 1000 hrs.

The family has concerns about the type of drugs and the manner in which they were administered.

The family are also concern that when Code A died Code A became extremely upset and the nursing staff asked the family to calm her down. As this appeared to be taking some time the nurses informed her brother that they would give her an injection to clam her. They thought this inappropriate without knowing Code A 's medical history. They do not know what drug the injection would contain.

The family wish to be notified personally in a family group.

I went back through the additional concerns to clarify all points and the family confirmed the contents of my notes.

Code A is concerned that notification may take place whilst she is out of the country visiting family.

She will probably travel in March/April time and would like to be advised if this would be around the time of notification.

Expert Review

Code A

No. BJC/07

Date of Birth:

Date of Death: **Code A**

Code A was admitted to Gosport War Memorial Hospital on 26 April 1999 for rehabilitation. He was transferred from the Royal Haslar Hospital where he had been admitted in April 1999 suffering a stroke. The stroke affected the left hand side of his body, this required Code A to have assistance with eating and drinking.

On 27 April 1999 Code A suddenly deteriorated becoming cyanosed dyspnoeic. This clinically appeared to be an extension of his previous stroke.

A syringe driver was set up with a high dose of Diamorphine and Midazolam. Code A died forty-five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Code A Code A noted that he may well have received less than normal since he had low blood pressure and was peripherally cyanosed.

The cause of death was shown as cerebral vascular accident and was certified by Code A was cremated.

The large dose of Diamorphine makes the care sub optimal but it had no effect on Code A s prognosis.

HAMPSHIRE CONSTABULARY

Code A

Code A

Code A

Date of Birth: Code A Age: **90**
Date of Admission to GWMH: **3rd August 1999**
Date of Death: Code A
Cause of Death:
Post Mortem:
Length of Stay: Code A **days**

Code A 's past medical history:

1987 – CA bladder/bowel
1992 - MI
1999 - Cystoscopy
1999 - Prostatectomy
Hypertension
CCF heart
CRF Kidneys
COPD pulmonary.

Code A was living independently at home. He had a home help and his neighbour would do the shopping for him. Code A had slightly impaired hearing but managed quite well. Code A had no family and his neighbour was noted as his next of kin. He was admitted to Haslar Hospital on 21st June 1999 with shortness of breath and underwent a transurethural resection of prostate and bladder biopsy. He was transferred to the Gosport War Memorial Hospital on 3rd August 1999 for rehabilitation.

On admission a handling profile was completed noting Code A needed the help of 1 to 2 nurses and a hoist for transfers. It also noted that he was nursed on a biwave plus mattress to prevent pressure damage.
A mouth assessment was undertaken as well as care plans for constipation, long term urinary catheter, hygiene and to settle at night.
A Waterlow score of 19-23 was recorded between August and September. As well as a Barthel ADL index for the same period with a score of between 6-3.
A nutritional assessment was completed in August with a score of 18 recorded.

3rd August 1999

Admitted to Gosport War Memorial Hospital from Haslar Hospital for rehabilitation. Pressure area were noted to be intact and that Code A had CA bladder he was in renal failure and that his mobilisation was not good.

16th August 1999

Not in pain. Reluctant to do much.

27th August 1999

Abdominal pain noted.

1st September 1999

Small sacral sore. 2 nurses and a hoist to transfer.

6th September 1999

Small split sacrum. Going downhill. Abdominal pain. Fentanyl given more comfortable.

Code A

Anxious – will have to have syringe driver. Syringe driver satisfactory 20mgs diamorphine.

17.30 hours – very rigid, very bubbly, deteriorated. **Syringe driver recharged with 50 mgs diamorphine.**

23.55 hours – died. Verified S/N Code A

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification Code A **Exhibit number**

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		Code A		
Unexplained By Illness C				

General Comments

Code A

Final Score:

Screeners Name: Code A
Date Of Screening:

Signature

Code A

Code A

Coloured Sticky Tab

Blue - OE end

Expert Review

Code A

No. BJC/12

Date of Birth:

Date of Death: **Code A**

Code A was admitted to Gosport War Memorial on 3 August 1999 following a resection of his prostate and a bladder biopsy at the Royal Haslar Hospital.

Although the original intention was that Code A would be transferred home with support, his condition deteriorated.

This case is made more difficult to analyse in the absence of a drug chart but it would appear that Code A 's analgesia was advanced from Paracetamol to Fentanyl.

By 6 September 1999 Code A was deteriorating. In the absence of a drug chart it is not possible to draw any conclusions as to whether this was related to his medication. On the day of Code A 's death, on Code A a syringe driver was set up containing 50mgs of Diamorphine and 20mgs of Midazolam. The Midazolam was doubled later that day.

Code A deteriorated rapidly and died and Code A raised concerns that the drugs administered via the syringe driver accelerated Code A s albeit inevitable death. Code A was the only expert that rated this case as negligent. In the absence of the drug chart, it is not possible to draw firm conclusions as to any liabilities in this case and no further investigation is advised.

CPT DOCUMENTS
END

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
16 September 2002

Code A
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: Code A

THE MDU

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Dear Code A

Code A

I write further to our telephone conversations today to assist in clarifying Code A s position. As I indicated in my previous letter to you, Code A will not be practicing during the currency of her sickness certificate – that being for 3 weeks from today's date. To clarify, Code A will not be practicing in any way over this period, be it NHS or private practice, given that ill-health.

Code A is happy to provide the assurance to you that if her position changes in this regard within the 3 week period, though there is no anticipation that it will do so, she will first notify the Council before resuming practice.

I hope this is of assistance, and once again please do not hesitate to contact me if I can assist further.

Yours sincerely

Code A

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: JZC/HJA/00492-14742/2180712 v1
Your ref: MK/2000/2047

Code A
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

9 January 2003

Dear Code A

Code A

I refer to the above matter.

Since my letter through to you dated 17 December 2002 I have attempted to forward the missing enclosures through e-mail. Each time I have done so a few days later I receive an indication that the documents have not been received with you! My last effort was on 24 December 2003 and I returned to the office yesterday – my first day back in the office since the Christmas break – to find another rejection advice.

I have checked the e-mail carefully and am using the following address: Code A I wonder if the documentation I am supplying occupies too much 'space' to be allowed through the GMC's firewalls. As technology has failed me, I enclose hard copy versions and apologise for the earlier omission.

As I indicated, a copy has been forwarded through to Code A has indicated that they wish to clarify certain aspects of the note. I await his amendments for inclusion in the note and for discussion with you.

As you are aware, Code A and I are scheduled to attend at the offices of CHI next week and we shall update you at our meeting on 22 January 2003. Would a time of 2.00pm be suitable for you? Unless I hear from you to the contrary, I look forward to meeting with you again then at our offices.

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London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

In your letter dated 18 December 2002 you request my thoughts on the inclusion of Code A s complaint under a Rule 11(2) referral. I thought that I had addressed this issue with you at our pre-meeting on 20 November 2002 at which I indicated that the other matters received by the GMC did appear appropriate to be considered under Rule 11(2).

I do not, however, consider that it would be appropriate for us to undertake any investigation at the moment as this may prejudice the enquiries being undertaken by Hampshire Constabulary. To determine definitively whether the complaint should go through to the PCC (if, indeed, we end up following a charge of serious professional misconduct as opposed to a criminal conviction), further enquiries will need to be undertaken and expert evidence obtained to determine the exact validity of the complaint.

One of the issues mentioned at our meeting in November was whether the police should receive all documentation the GMC hold in relation to this matter. My initial advice to you was that it would be appropriate for the material, in particular the documents considered by the PPC, the letters received on behalf of Code A the transcript of the IOC hearing and the additional papers received regarding the incident in 1991 to be disclosed. I confirm this advice. Within the Medical Act 1983 (as amended) the GMC made disclose "*to any person any information relating to a practitioner's professional conduct, professional performance or fitness to practise which they consider it to be in the public interest to disclose*" (Section 35B).

Are you content that it is in the public interest to disclose the material I have identified above? Should you confirm that the GMC consider it to be in the public interest, I shall pass the relevant documentation through to Code A

I hope that you had a restful Christmas and New Year break and that the move into your new home went smoothly.

See you next week!

Kind regards,

Yours sincerely

Code A

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Meeting note

Name: Code A	Call type: **Meeting**
Duration:	Date: **20 November 2002**

Code A - Pre-Meeting with FFW and GMC

Code A and Code A meeting with Code A prior to the meeting with the Hampshire Constabulary.

Code A advising Code A that this meeting was important to determine how Code A and the GMC could proceed with their enquiry. Code A advising that, to date, she had been reluctant to do anything other than read into the file owing to the possibility that action could prejudice the police enquiry.

Code A advising that she had identified the Chi documents she wished to obtain and, indeed, felt that it would be beneficial for her and Code A to go through to Chi and read the witness statements in order to identify who from the many statements taken should be proofed as part of the GMC enquiry. Code A agreeing this would be useful providing the police permitted Code A to undertake this task.

Code A advising that he had received a further letter from Alexander Harris (Solicitors for the relatives of the deceased elderly patients). Alexander Harris were concerned that the GMC should not proceed to a public hearing until the conclusion of the police matters. Code A recognising the advice from Code A and Code A that we would be unable to do anything if the police were investigating the matter further.

Code A also stating that she and Code A had briefly considered the further complaints. Stating that these appeared to be of similar kind enough allegations to allow the matters to be presented under Rule 11(2). Stating that we would, of course, have to identify the matters to the police and to offer them the opportunity to investigate the cases.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Meeting note

Name: Code A	Call type: **Meeting**
Duration:	Date: **20 November 2002**

Code A - Meeting with Hampshire Constabulary

Attendees:

GMC:
FFW:
Police:

Code A

Meeting

The attendees agreeing that Code A would make a brief minuted note of the meeting for circulation to all parties.

The parties introducing themselves and explaining their involvement in the case.

Code A explaining the situation within the GMC. Advising that the GMC would not proceed if Code A indicated that to do so could prejudice any policy enquiry. Code A explaining the difference between running the case as a conviction matter and one in which we had to prove serious professional misconduct. Code A indicating the criminal rules of evidence were applied in GMC proceedings.

Code A updating Code A and Code A as to the current position of the GMC enquiries. Indicating that the matter had both been screened and placed through the PPC.

Code A clarifying that the papers that the screener and the PPC had seen had been provided by Acting Code A Noting that these papers had been forwarded through to the GMC when it appeared that the police were no longer pursuing any criminal investigation. Code A advising that when, in 1998/1999 concern was raised by the death of Code A an investigation had taken place which the police admitted was not as effective as it should have been. Advising that the CPS had considered the investigation and, in particular, the report prepared by Code A on the Code A case and had taken the view that causation could not be made out.

Code A explaining that following the Code A conclusion, the families of the elderly patients stated that they considered the police had been too quick to conclude the matter and that as a consequence four other cases were "dip sampled" by a new investigating officer, Code A Those other cases were considered by two alternative experts Code A and Code A.

Code A indicating that he was concerned about the issue of causation and whether proving causation may be just outside of the Constabulary's reach. Noting, however, that although the file had been prepared again for the CPS (by Code A) and contained information on all five cases, there were a number of other incidents which still required full investigation. Code A indicating that on statistical analysis and a similar fact basis it may be possible to establish causation. Noting that there were significant arguments about the appropriateness of the prescribing regime and the instructions left by clinical staff. The attendees noting that this was a particular issue for professional regulation given that it was not necessary to show that causation resulted in death merely of the inappropriateness of the prescribing regime amounted to bad practice.

Code A advising that there were 50 other cases that the police may consider. One of the issues that would have to be resolved was whether a policy decision should be made to look at the hundreds of individuals who had died at the Gosport War Memorial Hospital. Noting that from 1994 to the period in which Code A resigned from the hospital, there were thousands of deaths, 600 of which had been certified by Code A There were further cases in which Code A had provided the care although the death may have been certified by a different practitioner.

Given the number of cases and the provisional views being provided by an alternative expert instructed by Code A stating that he was increasingly moving towards the view that he was entitled to argue that causation could be made out. Code A noting, however, the difficulty in showing that death through bronchial illness of pneumonia was a consequence of diamorphine. Although it was noted that excessive diamorphine could cause respiratory difficulties, the victims were elderly patients who were, therefore, vulnerable in any event.

Code A commenting that although there was a theme developing through the cases to suggest that Code A Code A had relied on diamorphine and syringe drivers, the police had to investigate the practices of the other practitioners working at Gosport Hospital. The attendees agreed that Code A could not be seen to be persecuted alone.

Code A noting that the environment in which Code A was working in which there were no prescribing policies may have allowed her to operate undetected.

Code A identifying the fact that in 1991 concerns had been raised regarding the use of diamorphine by junior nurses. Code A and Code A advising Code A that these papers had been provided to the GMC but did not take the matter further in terms of the interim procedures. Code A advising the circumstances in which the concerns had been made by the junior nurses and the fact that the medical practitioners and senior nurses had been opposed to any questioning of the clinical decision making. Noting that the fact that concerns had been raised some years previously did suggest that there was something amiss with Code A practice over a period of years.

Code A noting that there appeared to be a lack of motive. Code A was continuing to look at this element.

Code A advising that Code A had asked Code A to consider the issues raised by the cases identified by the police. Code A had persuaded Code A to also expand his enquiries into Code A 's GP practice. Code A noting that Code A 's analysis of the statistics would take some time.

Code A advising that the GMC had the power to make an interim order suspending or placing conditions upon a medical practitioner's registration notwithstanding the fact that he or she had not been found guilty of serious professional misconduct. Stating that in this instance the IOC had determined not to place any interim order upon Code A 's registration. Noting that this was based on a convincing argument by Code A explaining the lack of resources and supervision and the poor conditions under which she had had to work. Stating that given that the police were suggesting that there was potentially hundreds of deaths caused by Code A and were actively assessing whether a murder charge could be prosecuted, Code A would be concerned to protect the patients and the public interest by presenting new evidence to an IOC Panel.

The parties discussing the disclosure requirements for GMC. Noting that the GMC would be forced to disclose any document which they wished to present to an IOC hearing in reliance of a request for an interim order.

Code A appreciating the vulnerability of the GMC to criticism if a patient was killed at the hands of Code A Code A when the GMC could have taken action to prevent her from practising. He was, however, concerned regarding disclosure of material which he would not wish revealed to the doctor at too early a stage. Code A stating that it would possible for him to write a letter for the GMC indicating that police investigations were continuing and that there were a minimum of 50 patients whose deaths would be analysed. The letter could also advise that early medical advice suggested that the deaths had been hastened by the prescribing regime provided by Code A The attendees agreeing that the letter from Code A would also formally request that the GMC state their proceedings.

Code A expressing concern that the defence could argue that Code A was no longer working at Gosport War Memorial Hospital and, therefore, patients were not at risk from diamorphine prescriptions or syringe drivers. Code A noting in this regard that Code A 's private practice would include elderly patients. Code A commenting that although she appreciated that it had not yet been determined whether the criminal enquiry should consider the private/GP practice, it would be helpful if the fact that investigations may be expanded in this direction could be included within the letter to the GMC. Code A stating that whilst he would wish to assist the GMC as far as possible, it may be

difficult for him to add this element to any letter. Noting that Code A had agreed to expand his analysis to include Code A's private practise, but this was not part of his specific remit established by Code A

Code A advising that the letter to the GMC would also formally establish the Constabulary's commitment to liaise closely with the GMC. The parties agreeing that formal letters would be written outlining information that was possible for the GMC to disclose. There would also be contact through e-mail, telephone and further meetings. Code A advising that she was likely to phone Code A on a monthly basis so that she could report back to the GMC in her monthly reports!

The parties noting that Alexander Harris had expressed concern that the individuals involved in the various investigations and enquiries were not liaising. Noting the commitment to liaise closely could be articulated to Code A at Alexander Harris - it would, however, be necessary to stress the different role that each of the particular stakeholders were bound to adopt. Detail would not be provided about the level of communication or the information being passed between the parties but Alexander Harris should be advised that formal channels of communication had been developed.

In this regard, Code A advising that he had met with Code A last week. The meeting had been productive in that it had been on a non-adversarial basis. Stating that Code A had used the media to generate publicity for her firm following the meeting, however, formal channels of communication had been established and it had been agreed that the family could raise concerns regarding any police investigation through Alexander Harris. Hampshire Constabulary had also agreed to advise any new individuals that Alexander Harris were acting for relatives; Code A stressing that this would not be a referral service but merely informative.

Code A stating that an important date was his meeting with the CPS scheduled for 28 November 2002. This meeting would establish the Constabulary's expectations as to the speed with which the CPS should consider the papers. Code A advising that if the CPS did not consider the matter should proceed to a prosecution, the case could be considered by Treasury Counsel (an alternative Treasury Counsel from that which considered the initial referral of the Code A case).

Code A querying whether the GMC had any record of Code A's qualifications as he did not have a full history or CV. The GMC would attempt to track down as much information as possible.

The GMC also would pass on any Rule 6 response letter if appropriate. Code A also advising that the GMC had received two other complaints Code A and Code A and Code A did not recognise these names as individuals within the 50 cases being investigated by the Constabulary. Code A to pass the documents through to the Constabulary.

There appeared to be a culture of resorting to diamorphine care too quickly (perhaps for a easy life?). The parties identified the fact that there may be problems with other doctors. Code A advising Code A and Code A that the case against Code A had been "screened" within the GMC procedures and a decision taken not to pursue the matter.

As regards disclosure, Code A stating that she would work on the assumption that any documents provided by the police would be undisclosable unless she was specifically advised otherwise in writing. Code A stating that the GMC enquiry, once it was permitted to proceed would, of course, have to disclose any documentation passed through by the police. Code A and Code A appreciating this fact and noting that at that stage, in any event, the policy enquiry would be concluded. Code A stating that once the police enquiry was concluded it would be possible to pass Code A all relevant documentation and, indeed, this was the basis on which the police worked.

Code A explaining that we had received a report from CHI. She explained that we wished to obtain the documents that had been considered by the CHI investigation team and, moreover, visit CHI in order to analyse the witness statements taken. Stating that there would be no intention to interview the witnesses. Code A agreeing that this would not prejudice any police investigation and Code A and Code A could proceed with this aspect of the GMC enquiry.

The parties summarising the fact that Code A would provide a letter to the GMC which could be used by the GMC in an IOC hearing, which would formally ask the GMC to stay their investigations and which would state that the parties were committed to regular liaison. Code A and Code A noting that it may be difficult to persuade an IOC panel to place an interim order based only on a letter but identifying that this was the best position). Code A advising that the police would advise the GMC of any significant event and would release information if it was appropriate for them to do so.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

attendance note of meeting

Name: Code A	Call type: **Meeting**
Att: Code A	From:
Duration:	Date: **3 October 2002**

Meeting re: Code A

Attendees:

GMC - **Code A**

FFW - Code A

Issues

Code A identifying the fact that there were five issues that he particularly wished to discuss with the GMC and that these were as follows:

1. **Code A**
2. Police involvement
3. Further cases
4. 1991 allegations
5. Timescale

1991 Allegations

Code A indicating that he doubted that the other information received regarding the 1991 allegations would add anything to the case and would not be sufficient evidence to add weight to an argument for an Interim Order. Code A advising that, technically, the information regarding the 1991 allegations was new evidence and did show that the concerns were long-standing. Code A advising that although the new information could be regarded as "trigger papers" there was an abuse point and it was possible that the Screener would determine that they did not add anything to the weight of the existing allegations.

Code A and Code A identifying the fact that there was a political aspect to this case and that local individuals, such as Code A were under some pressure. Code A advising that he would provide written advice on the issue on headed FFW paper.

Timescale

The attendees accepting that the speed with which the matter could be progressed would be affected by the police investigation and any prosecution by the CPS. It was identified that it may be helpful if the police could provide the papers on the understanding that the GMC would do nothing with the information until the conclusion of the prosecution or investigation. This would, however, enable the GMC to be ready to 'roll out' the matter quickly once there was no prejudice to the regulatory inquiry.

The parties discussing the level of Counsel to become involved in the case. The GMC accepting that owing to the public profile of the case it would be beneficial to instruct a QC at an early stage.

Code A suggesting that the matter could be listed for March.

Noting that the CHI Report may have helpful information and statements which could be utilised. In addition, CHI may have obtained the necessary consent and medical records.

General

Code A advising Code A and Code A that the case provided by Code A to the IOC was *"very powerful"*. Neither Code A nor Code A had read the IOC transcript or response letter. Code A advising that owing to the particular resource issues identified within Code A s response, it may be difficult to attach sole blame for hastening death to the doctor. Noting, however, that following receipt of the 1991 allegations there had been long-standing concerns regarding treatment which ended life. The parties agreeing that there did appear to be problems with the doctor's practice but this was not a Shipmanesque case.

Code A stating that this was a case in which there was indirect pressure for the GMC to push on with its enquiries. Code A emphasising that there was no agenda to achieve a particular result. The GMC would, however, have to ensure that all matters were fully explored.

Code A pointing out that the Report prepared by CHI would provide useful background information. We would wish to see everything that the investigators for CHI had obtained.

Code A requesting an update about the police investigation if the GMC had recently received one. Code A stating that it appeared that nothing much had changed. The matter had been submitted to the CPS and unofficially it appeared that the matter would not proceed.

The parties agreeing that an early meeting with Code A would be useful in order to establish what was going on.

The parties discussing the difficulties that would be presented by the fact that both Code A Code A) and the nurses involved in the case may be the subject of regulatory proceedings through the GMC and the UKCC. Advising that it would not be possible for these individuals to give evidence at any regulatory proceedings as to do so would be to give evidence which could potentially self-incriminate the individual.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: JZC/HJA/00492-14742/2145525 v1
Your ref: MK/2000/2047

Code A
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

17 December 2002

Dear Code A

Code A

Thank you for copies of the letters you have recently sent through to Alexander Harris.

Following our meeting with the Hampshire Constabulary on 20 November 2002 I thought it would be helpful to send you an update.

Attendance Notes

I enclose a copy of the attendance note of the meeting held on 3 October 2002. I noted, on a review of the file, that I had not forwarded the document to you earlier. You may wish to add this to your file for information.

In addition, I enclose a copy of the meeting note taken after the meeting with Hampshire Constabulary last month. I have forwarded a copy of the note to Code A together with a request that he advises me of any changes he wishes incorporated into the document. Should any amendments be made, I shall forward a further copy of the note to you.

Hampshire Constabulary

I recently received the enclosed letter from Code A which formally requests that the GMC's enquiries and proceedings are stayed pending the outcome of the criminal investigation. As Code A suggested at the meeting, our hearing date of April 2003 should be vacated as the police investigation is likely to be lengthy; indeed it appears that following the meetings with the CPS a decision has been

taken to enlarge the parameters of the investigation. If the expansion involves the hundreds of patients who were certified dead by Code A and treated by her during their stay at Gosport War Memorial Hospital, the investigation could take, as we were warned, some years. When I next speak with Code A on the telephone I will attempt to get some indication of the degree to which the enquiries have been enlarged.

I should be grateful if you could provide me with instructions to write to Hampshire Constabulary to advise them formally that the GMC proceedings will be stayed pending the outcome of the police investigation. Currently I have acknowledged Code A's letter and indicated that we are seeking your formal response.

Commission for Health Improvement

At the meeting you will recall that Code A provided with specific permission to contact CHI in order to examine their documents and the statements they had obtained during their Inquiry. The permission was granted on the basis that we would not contact any of the individuals but were merely assessing the documents and the material held by CHI.

Following the meeting and prior to my holiday last week, I wrote to Code A at CHI requesting a number of documents and asking for inspection facilities in respect of the witness statements and other material held by CHI. I have received a response from Code A who has indicated her willingness to cooperate with the GMC's enquiries. Unfortunately, it has not been possible to find a two-day slot in which my, Code A s and Code A 's diaries are all free until 14-15 January 2003. Given, however, the fact that we will be unable to hold the hearing in April 2003, I do not consider that it is of concern that we must wait until mid-January before visiting CHI. I hoe that you agree.

In light of the fact that it has not been possible to arrange an appointment with CHI prior to the New Year, I wonder whether it would be beneficial for us to postpone the meeting tentatively arranged for 8 January 2002 to 22 January 2002. This would allow Code A and I to update to as to the documents and information we obtained from our visit to CHI. Are you free on this date?

I look forward to hearing from you.

Kindest regards,

Code A

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: MSL/TL/00492-14742/2065792 v1
Your ref: MK/2000/2047

Code A
Conduct Case Presentation Section
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London W1W 5JE

9 October 2002

Dear Code A

Code A

[redacted]

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London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

[redacted]

Yours sincerely

Code A

Please quote our reference when communicating with us about this matter

Our ref: ISPB/sls/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
17 September 2002

THE MDU

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Code A
General Medical Council
178 Great Portland Street
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Also by fax: 0207-915-7406

Dear Code A

Interim Orders Committee - Code A

I write with reference to your letter to my client, Code A of 13 September 2002.

With reference to the Rule 11 of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000, I would be grateful if you would kindly make available to me all documents in this matter as a matter of urgency. In particular, I would be grateful for sight of any communications between the Council and the Department of Health whether in letter form or notes of telephone communication.

Yours sincerely

Code A

17/09 '02 13:55 FAX Code A THE M D U LEGAL 001

THE MDU

The Medical Defence Union Limited
Legal Department

Facsimile

To:	Code A
Company:	General Medical Council
Fax no:	Code A
From:	Code A
Date sent:	17 September 2002
Time sent:	
No. of sheets inclusive:	2
Re:	Code A

If you do not receive legible copies of all the pages please notify us immediately by telephone or fax.

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Please quote our reference when communicating with us about this matter

Our ref: ISPB/sls/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
17 September 2002

Code A
General Medical Council
178 Great Portland Street
London
W1W 5JE
Also by fax: Code A

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: mdu@the-mdu.com
Website www.the-mdu.com

Dear Code A

Interim Orders Committee - Code A

I write with reference to your letter to my client, Code A of 13 September 2002.

With reference to the Rule 11 of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000, I would be grateful if you would kindly make available to me all documents in this matter as a matter of urgency. In particular, I would be grateful for sight of any communications between the Council and the Department of Health whether in letter form or notes of telephone communication.

Yours sincerely

Code A

Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Tel: 01329 233447
Fax: 01329 234984

Direct Line: Code A
Direct Fax:

Code A
General Medical Council
2nd Floor, Regents Place
350 Euston Road
London
NW1 3JN

25th November 04

Dear Code A

RE: Code A

I have met with Code A on three occasions since October 2002 in order to examine the prescribing data supplied by the Prescription Pricing Authority (PPA). At our last meeting, we looked at the data for benzodiazepine and opiate prescribing from October 2002 until August 2004. The PPA records prescribing data according to the named GP on the bottom of the prescription form NOT the GP signing the form. Consequently, a number of prescriptions were attributed to Code A which had been initiated by another partner. Code A has agreed to take certain actions, following our last meeting, the details of which are included in the report.

I am enclosing copies of the PPA data, together with graphs and the reports of our meetings. If I can be of any further help, please contact me.

Yours sincerely

Code A

Code A

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Code A Oct 2002 - March 20

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Diazepam_Tab 5mg	2	60.0	£2.29
October 2002	Diazepam_Tab 5mg	1	28.0	£0.55
October 2002	Diazepam_Tab 5mg	1	56.0	£1.07
October 2002	Diazepam_Tab 2mg	2	60.0	£2.11
October 2002	Diazepam_Tab 2mg	1	28.0	£0.51
October 2002	Diazepam_Tab 5mg	1	30.0	£0.59
October 2002	Temazepam_Tab 10mg	1	56.0	£1.65
October 2002	Lorazepam_Tab 1mg	1	28.0	£1.16
October 2002	Diazepam_Oral Soln 2mg/5ml S/F	1	200.0	£2.64
October 2002	Diazepam_Tab 10mg	1	60.0	£1.65
October 2002	Nitrazepam_Tab 5mg	1	60.0	£1.61
October 2002	Nitrazepam_Tab 5mg	1	56.0	£1.51
October 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Diazepam_Tab 5mg	1	28.0	£0.55
December 2002	Diazepam_Tab 5mg	1	60.0	£1.15
December 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Temazepam_Tab 20mg	1	30.0	£1.50
January 2003	Diazepam_Tab 2mg	2	28.0	£1.02
January 2003	Diazepam_Tab 2mg	1	56.0	£0.98
January 2003	Temazepam_Tab 20mg	1	28.0	£1.41
February 2003	Diazepam_Tab 2mg	3	28.0	£1.52
February 2003	Temazepam_Tab 10mg	1	56.0	£1.62
March 2003	Diazepam_Tab 5mg	1	6.0	£0.14
March 2003	Diazepam_Tab 5mg	2	28.0	£1.11
		30		*£31.13*

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines 2003-4

Code A

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
May 2003	Diazepam_Tab 2mg	1	28.0	£0.51
May 2003	Diazepam_Tab 10mg	1	60.0	£1.65
June 2003	Diazepam_Tab 2mg	1	28.0	£0.51
June 2003	Diazepam_Tab 2mg	1	6.0	£0.13
June 2003	Temazepam_Oral Soln 10mg/5ml S/F	1	100.0	£3.01
June 2003	Diazepam_Tab 5mg	2	28.0	£1.11
July 2003	Diazepam_Tab 2mg	1	28.0	£0.51
July 2003	Diazepam_Tab 10mg	1	60.0	£1.65
September 2003	Chlordiazepox HCl_Cap 5mg	1	52.0	£1.96
October 2003	Diazepam_Tab 2mg	1	28.0	£0.51
October 2003	Diazepam_Tab 2mg	1	10.0	£0.20
October 2003	Diazepam_Tab 5mg	1	10.0	£0.22
November 2003	Diazepam_Tab 2mg	1	21.0	£0.39
November 2003	Diazepam_Tab 2mg	1	28.0	£0.51
November 2003	Diazepam_Tab 5mg	1	60.0	£1.15
December 2003	Diazepam_Tab 2mg	1	28.0	£0.51
February 2004	Diazepam_Tab 2mg	2	28.0	£1.02
February 2004	Diazepam_Tab 5mg	1	56.0	£1.08
		20		***£16.63***

Based on the Selections:

1st Quarter 2003/2004,
2nd Quarter 2003/2004,
3rd Quarter 2003/2004,
4th Quarter 2003/2004
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Code A April - August 200

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Diazepam_Tab 2mg	1	28.0	£0.51
April 2004	Lorazepam_Tab 1mg	1	28.0	£1.16
May 2004	Diazepam_Tab 2mg	1	60.0	£1.06
May 2004	Nitrazepam_Tab 5mg	1	56.0	£1.53
June 2004	Diazepam_Tab 2mg	1	60.0	£1.06
June 2004	Diazepam_Tab 2mg	1	28.0	£0.51
June 2004	Diazepam_Tab 5mg	3	14.0	£0.88
July 2004	Diazepam_Tab 5mg	2	14.0	£0.59
July 2004	Temazepam_Tab 10mg	1	56.0	£1.75
August 2004	Diazepam_Tab 2mg	1	28.0	£0.51
		13		***£9.56***

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

Prescribing Report Opiates Code A Oct 2002 - March 2003

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
October 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
October 2002	Tramadol HCl_Cap 50mg	1	30.0	£2.76
October 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£8.52
October 2002	Tramadol HCl_Cap 50mg	1	90.0	£8.22
November 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
November 2002	Codeine Phos_Tab 30mg	1	60.0	£2.82
December 2002	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.43
December 2002	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.64
December 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
December 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
December 2002	Tramadol HCl_Cap 50mg	1	100.0	£9.36
January 2003	Codeine Phos_Tab 30mg	1	60.0	£2.82
January 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
January 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
January 2003	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
January 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.74
February 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
February 2003	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.63
February 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
February 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.93
March 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
March 2003	Tramadol HCl_Tab 100mg M/R	2	60.0	£32.88
March 2003	Tramadol HCl_Cap 50mg	2	60.0	£11.26
March 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.58
March 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.43
		29		*£200.48*

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,

NHS

Prescription Pricing Authority

Prescribing Report Opiates Code A 2003-4

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
April 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.42
May 2003	Codeine Phos_Tab 30mg	2	60.0	£5.65
May 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
May 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
May 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
June 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
June 2003	Mst Continus_Tab 10mg	1	120.0	£10.96
June 2003	Mst Continus_Tab 60mg	1	60.0	£25.63
June 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£3.20
June 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.68
June 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
July 2003	Codeine Phos_Tab 30mg	1	240.0	£11.19
July 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
July 2003	Codeine Phos_Tab 30mg	2	60.0	£5.44
July 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.93
July 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
August 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
August 2003	Dihydrocodeine Tart_Tab 30mg	1	40.0	£1.97
September 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
September 2003	Morph Sulph_Tab 15mg M/R	1	42.0	£6.75
September 2003	Zydol_Cap 50mg	1	60.0	£9.14
September 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.74
September 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
September 2003	Codeine Phos_Tab 30mg	2	60.0	£5.42
October 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.14
October 2003	Meptazinol HCl_Tab 200mg	1	60.0	£10.72
October 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.37
October 2003	Codeine Phos_Tab 30mg	1	60.0	£2.84
November 2003	Tramadol HCl_Cap 100mg M/R	1	28.0	£6.95
November 2003	Tramadol HCl_Cap 50mg	1	84.0	£7.87
November 2003	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.79
December 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
December 2003	Codeine Phos_Tab 30mg	2	60.0	£5.46
January 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
January 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
February 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
February 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
February 2004	Dihydrocodeine Tart_Tab 30mg	1	180.0	£5.77
February 2004	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.76
March 2004	Codeine Phos_Tab 30mg	1	60.0	£2.62
March 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.38
March 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90

52 *£340.81*

Based on the Selections:

Financial 2003/2004
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

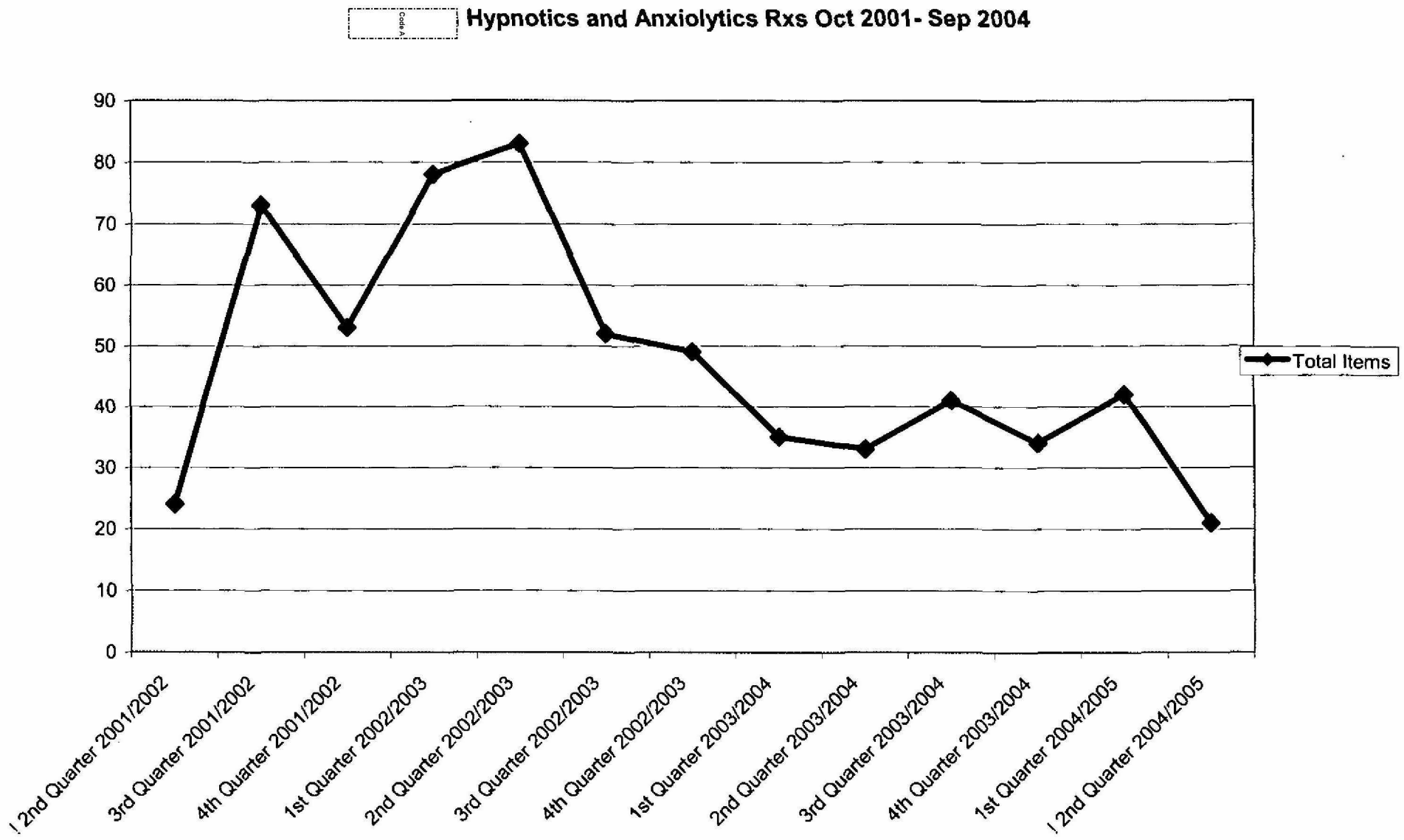
Prescribing Report Opiates Code A April - August 2004

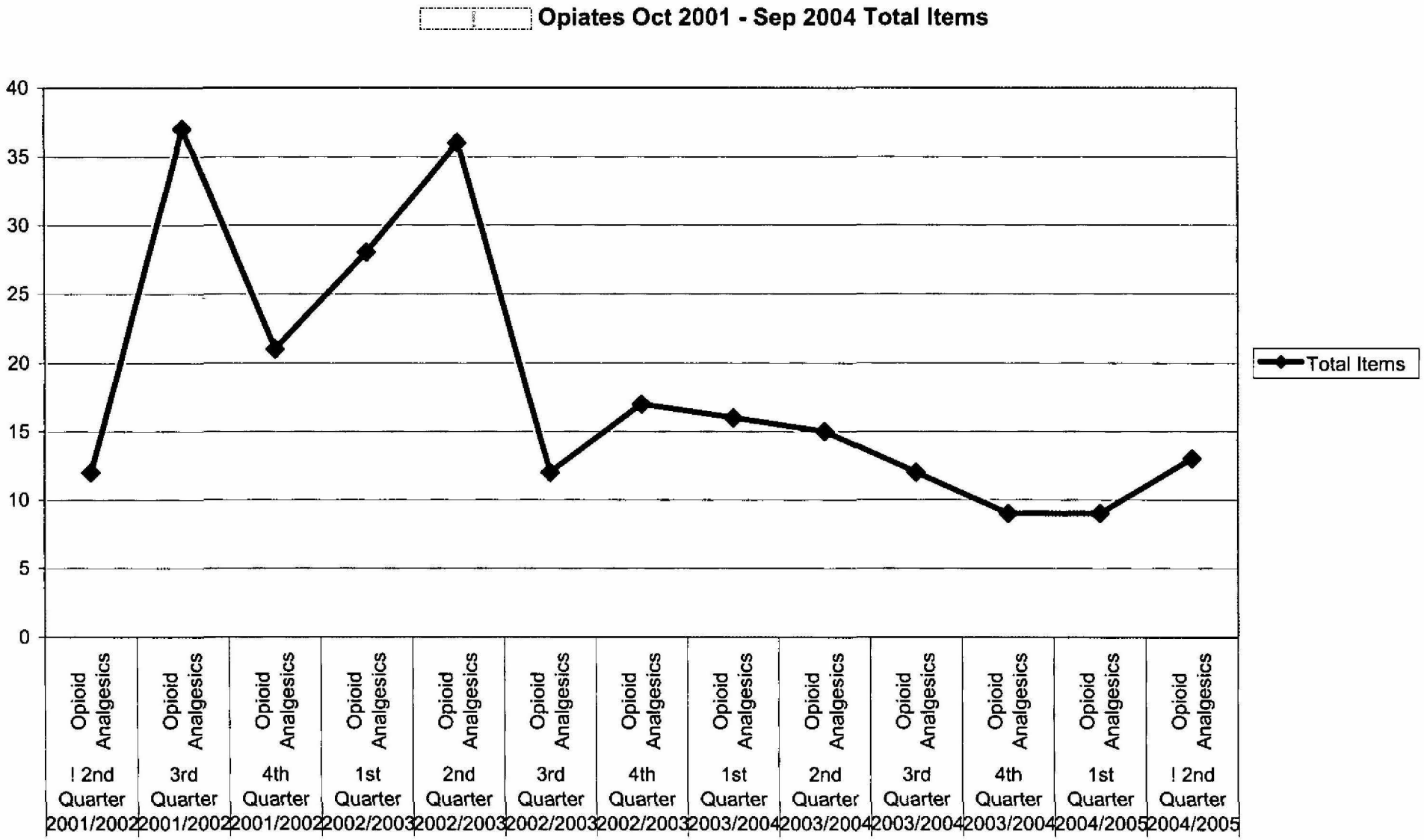
Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.13
April 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
April 2004	Tramadol HCl_Cap 50mg	2	150.0	£28.07
May 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
June 2004	Tramadol HCl_Tab 100mg M/R	2	60.0	£33.02
June 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
July 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
July 2004	Tramadol HCl_Tab 100mg M/R	3	60.0	£49.49
July 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.89
July 2004	Tramadol HCl_Cap 50mg	2	100.0	£18.71
August 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
August 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
August 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.12
August 2004	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.86
August 2004	Tramadol HCl_Cap 50mg	1	150.0	£13.67
		22		*£221.38*

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.





Meetings with Code A

The meetings were held to discuss matters raised in the CHI report on Gosport War Memorial Hospital. PACT data was obtained for 2001-2 to establish Code A s prescribing patterns for benzodiazepines and opiates (see attached PPA data and analysis table). PACT catalogue data is also available on file.

Meeting on November 1st 2002.

Code A has undertaken not to prescribe benzodiazepines or opiate analgesics from October 1st 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.

Code A will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health Call as a prescription may be required for a 14-day supply of benzodiazepines for bereavement.

Code A also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patients' notes.

The next meeting will be in 6 months time

Visits to local pharmacies for spot checks on Code A s prescriptions was discussed and deemed to be impractical.

Meeting on June 27th 2003

Data was available from the PPA up to and including April 2003. 12 months data was discussed.

Code A had initiated searches on the practice computer system and the data collected by the practice Code A for the 4th quarter of 2002-3 was studied. 7 of the 8 diazepam prescriptions had been prescribed by other partners for Code A s patients.

Copies of the breakdown of PACT data from October 2002 to April 2003 for nitrazepam, temazepam, diazepam and opiates were given to Code A Monthly reports on these drugs will be prepared for Code A

Code A
Fareham and Gosport PCT
05.09.03

Notes from meeting with Code A

3rd November 2004

Details of the voluntary agreement - from October 2002 as confirmed in an e-mail from Code A. It was agreed that this should run until Code A had been before the Conduct Committee. The agreement was for a restriction on the prescribing of opiates and for benzodiazepines to only be prescribed in line with BNF guidance.

The Prescription Pricing Authority data was examined for the period October 2002 until August 2004 (the latest data on the system at the time of the meeting). Code A Code A had made great efforts to transfer patients requiring opiates or benzodiazepines to other partners within the practice. The practice data analyst had produced a list of the prescriptions for diazepam 2mg, which had been issued with Code A Code A's name as the prescriber. Code A had written 5 prescriptions and a reason for the treatment was documented. The remaining prescriptions had been issued during consultations with other partners.

Only 3 of the opiate prescriptions were for controlled drugs in tablet form. Code A will ask the practice data analyst to follow up this matter. The remainder of the prescriptions were for drugs such as codeine phosphate, tramadol and dihydrocodeine tablets or capsules.

Code A will also ask the data analyst to follow up the diazepam 10mg prescriptions.

As far as Code A is concerned, the voluntary agreement is still in place. The agreement for opiates was a restriction on controlled drugs, in particular, for injection.

The PPA data is recorded against the GP name printed in the bottom of the prescription not against the signature. Code A continues to assure me that all patients requiring long-term treatment with opiates or benzodiazepines are asked to see other partners within the practice.

Code A
Fareham and Gosport PCT
04.11.04

Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Tel: 01329 233447
Fax: 01329 234984

Code A

Code A
General Medical Council
2nd Floor, Regents Place
350 Euston Road
London
NW1 3JN

25th November 04

Dear Code A

RE: Code A

I have met with Code A on three occasions since October 2002 in order to examine the prescribing data supplied by the Prescription Pricing Authority (PPA). At our last meeting, we looked at the data for benzodiazepine and opiate prescribing from October 2002 until August 2004. The PPA records prescribing data according to the named GP on the bottom of the prescription form NOT the GP signing the form. Consequently, a number of prescriptions were attributed to Code A, which had been initiated by another partner. Code A has agreed to take certain actions, following our last meeting, the details of which are included in the report.

I am enclosing copies of the PPA data, together with graphs and the reports of our meetings. If I can be of any further help, please contact me.

Yours sincerely

Code A

Code A

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Code A
Oct 2002 - March 20

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Diazepam_Tab 5mg	2	60.0	£2.29
October 2002	Diazepam_Tab 5mg	1	28.0	£0.55
October 2002	Diazepam_Tab 5mg	1	56.0	£1.07
October 2002	Diazepam_Tab 2mg	2	60.0	£2.11
October 2002	Diazepam_Tab 2mg	1	28.0	£0.51
October 2002	Diazepam_Tab 5mg	1	30.0	£0.59
October 2002	Temazepam_Tab 10mg	1	56.0	£1.65
October 2002	Lorazepam_Tab 1mg	1	28.0	£1.16
October 2002	Diazepam_Oral Soln 2mg/5ml S/F	1	200.0	£2.64
October 2002	Diazepam_Tab 10mg	1	60.0	£1.65
October 2002	Nitrazepam_Tab 5mg	1	60.0	£1.61
October 2002	Nitrazepam_Tab 5mg	1	56.0	£1.51
October 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Diazepam_Tab 5mg	1	28.0	£0.55
December 2002	Diazepam_Tab 5mg	1	60.0	£1.15
December 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Temazepam_Tab 20mg	1	30.0	£1.50
January 2003	Diazepam_Tab 2mg	2	28.0	£1.02
January 2003	Diazepam_Tab 2mg	1	56.0	£0.98
January 2003	Temazepam_Tab 20mg	1	28.0	£1.41
February 2003	Diazepam_Tab 2mg	3	28.0	£1.52
February 2003	Temazepam_Tab 10mg	1	56.0	£1.62
March 2003	Diazepam_Tab 5mg	1	6.0	£0.14
March 2003	Diazepam_Tab 5mg	2	28.0	£1.11
		30		*£31.13*

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines 2003-4

Code A

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
May 2003	Diazepam_Tab 2mg	1	28.0	£0.51
May 2003	Diazepam_Tab 10mg	1	60.0	£1.65
June 2003	Diazepam_Tab 2mg	1	28.0	£0.51
June 2003	Diazepam_Tab 2mg	1	6.0	£0.13
June 2003	Temazepam_Oral Soln 10mg/5ml S/F	1	100.0	£3.01
June 2003	Diazepam_Tab 5mg	2	28.0	£1.11
July 2003	Diazepam_Tab 2mg	1	28.0	£0.51
July 2003	Diazepam_Tab 10mg	1	60.0	£1.65
September 2003	Chlordiazepox HCl_Cap 5mg	1	52.0	£1.96
October 2003	Diazepam_Tab 2mg	1	28.0	£0.51
October 2003	Diazepam_Tab 2mg	1	10.0	£0.20
October 2003	Diazepam_Tab 5mg	1	10.0	£0.22
November 2003	Diazepam_Tab 2mg	1	21.0	£0.39
November 2003	Diazepam_Tab 2mg	1	28.0	£0.51
November 2003	Diazepam_Tab 5mg	1	60.0	£1.15
December 2003	Diazepam_Tab 2mg	1	28.0	£0.51
February 2004	Diazepam_Tab 2mg	2	28.0	£1.02
February 2004	Diazepam_Tab 5mg	1	56.0	£1.08
		20		*£16.63*

Based on the Selections:

1st Quarter 2003/2004,
2nd Quarter 2003/2004,
3rd Quarter 2003/2004,
4th Quarter 2003/2004
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Code A April - August 200

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Diazepam_Tab 2mg	1	28.0	£0.51
April 2004	Lorazepam_Tab 1mg	1	28.0	£1.16
May 2004	Diazepam_Tab 2mg	1	60.0	£1.06
May 2004	Nitrazepam_Tab 5mg	1	56.0	£1.53
June 2004	Diazepam_Tab 2mg	1	60.0	£1.06
June 2004	Diazepam_Tab 2mg	1	28.0	£0.51
June 2004	Diazepam_Tab 5mg	3	14.0	£0.88
July 2004	Diazepam_Tab 5mg	2	14.0	£0.59
July 2004	Temazepam_Tab 10mg	1	56.0	£1.75
August 2004	Diazepam_Tab 2mg	1	28.0	£0.51
		13		*£9.56*

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

Prescribing Report Opiates Code A Oct 2002 - March 2003

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
October 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
October 2002	Tramadol HCl_Cap 50mg	1	30.0	£2.76
October 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£8.52
October 2002	Tramadol HCl_Cap 50mg	1	90.0	£8.22
November 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
November 2002	Codeine Phos_Tab 30mg	1	60.0	£2.82
December 2002	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.43
December 2002	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.64
December 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
December 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
December 2002	Tramadol HCl_Cap 50mg	1	100.0	£9.36
January 2003	Codeine Phos_Tab 30mg	1	60.0	£2.82
January 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
January 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
January 2003	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
January 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.74
February 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
February 2003	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.63
February 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
February 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.93
March 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
March 2003	Tramadol HCl_Tab 100mg M/R	2	60.0	£32.88
March 2003	Tramadol HCl_Cap 50mg	2	60.0	£11.26
March 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.58
March 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.43
		29		***£200.48***

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,

NHS

Prescription Pricing Authority

Prescribing Report Opiates Code A 2003-4

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
April 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.42
May 2003	Codeine Phos_Tab 30mg	2	60.0	£5.65
May 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
May 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
May 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
June 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
June 2003	Mst Continus_Tab 10mg	1	120.0	£10.96
June 2003	Mst Continus_Tab 60mg	1	60.0	£25.63
June 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£3.20
June 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.68
June 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
July 2003	Codeine Phos_Tab 30mg	1	240.0	£11.19
July 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
July 2003	Codeine Phos_Tab 30mg	2	60.0	£5.44
July 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.93
July 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
August 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
August 2003	Dihydrocodeine Tart_Tab 30mg	1	40.0	£1.97
September 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
September 2003	Morph Sulph_Tab 15mg M/R	1	42.0	£6.75
September 2003	Zydol_Cap 50mg	1	60.0	£9.14
September 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.74
September 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
September 2003	Codeine Phos_Tab 30mg	2	60.0	£5.42
October 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.14
October 2003	Meptazinol HCl_Tab 200mg	1	60.0	£10.72
October 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.37
October 2003	Codeine Phos_Tab 30mg	1	60.0	£2.84
November 2003	Tramadol HCl_Cap 100mg M/R	1	28.0	£6.95
November 2003	Tramadol HCl_Cap 50mg	1	84.0	£7.87
November 2003	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.79
December 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
December 2003	Codeine Phos_Tab 30mg	2	60.0	£5.46
January 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
January 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
February 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
February 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
February 2004	Dihydrocodeine Tart_Tab 30mg	1	180.0	£5.77
February 2004	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.76
March 2004	Codeine Phos_Tab 30mg	1	60.0	£2.62
March 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.38
March 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90

52 £340.81

Based on the Selections:

Financial 2003/2004
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

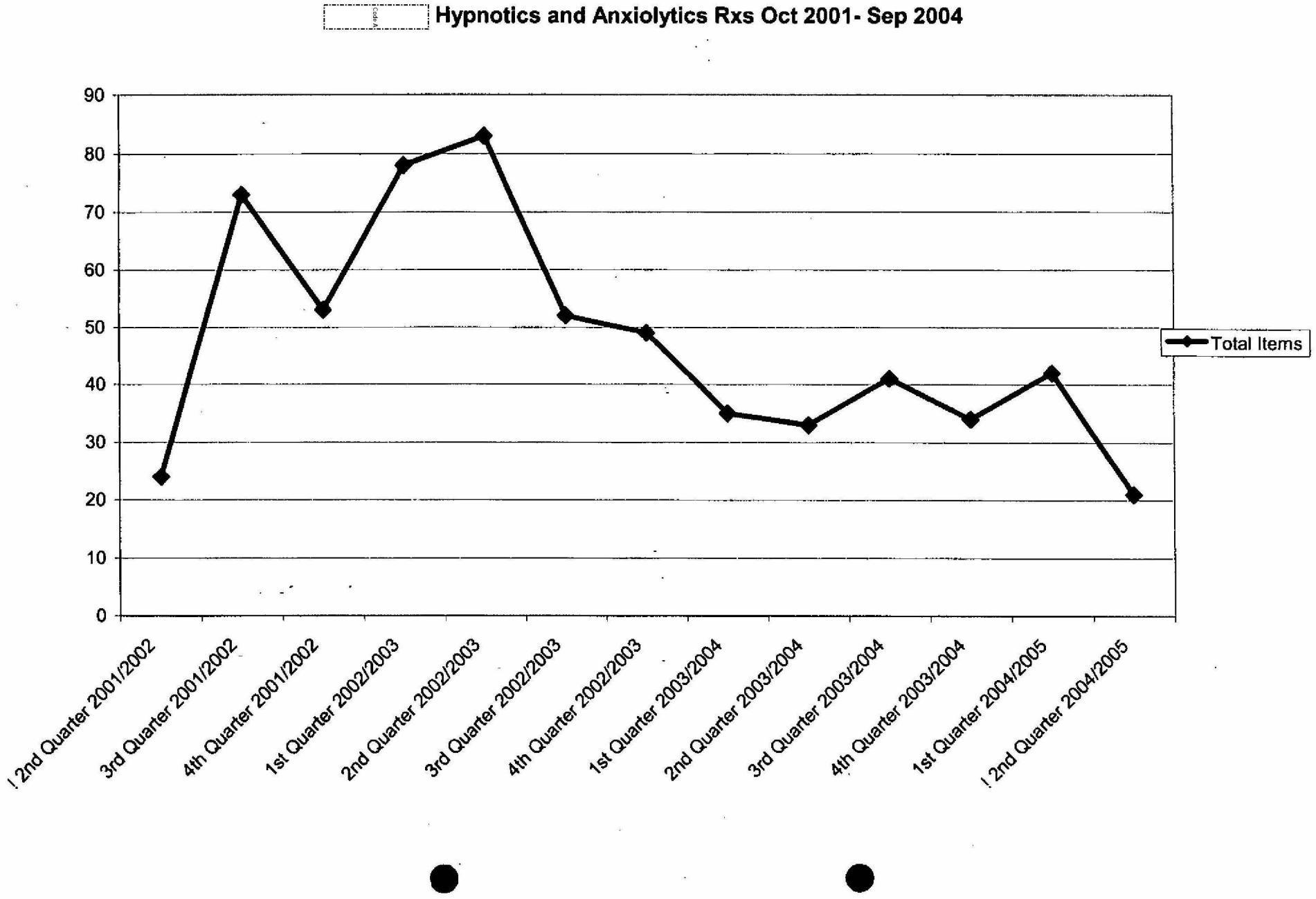
Prescribing Report Opiates Code A April - August 2004

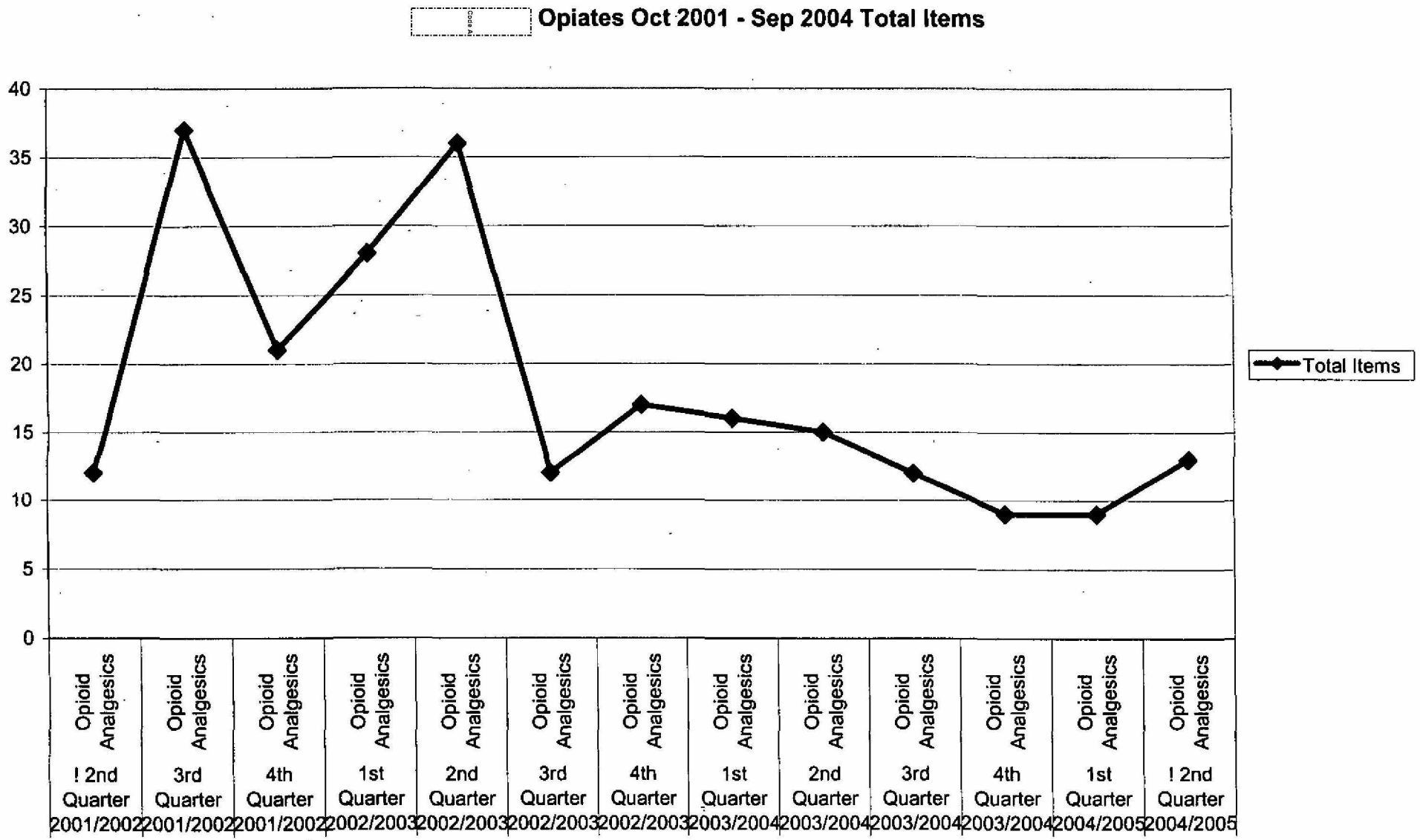
Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.13
April 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
April 2004	Tramadol HCl_Cap 50mg	2	150.0	£28.07
May 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
June 2004	Tramadol HCl_Tab 100mg M/R	2	60.0	£33.02
June 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
July 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
July 2004	Tramadol HCl_Tab 100mg M/R	3	60.0	£49.49
July 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.89
July 2004	Tramadol HCl_Cap 50mg	2	100.0	£18.71
August 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
August 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
August 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.12
August 2004	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.86
August 2004	Tramadol HCl_Cap 50mg	1	150.0	£13.67
		22		*£221.38*

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Code A
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.





From:- Code A

F.A.O.:- Code A
CCP Section, GM Council,
2nd Floor, Regents Place,
350 Euston Road, London.
NW1 3JN

Subject Reference №: PCH/2000/2047
Code A Deceased

Dear Sir

We as a Family(Six of Code A living around the U/K) apologise for the delay in a reply to you letter dated 5th October 2004, the contents plus the Hampshire Police letter on our Code A **'Treatment'**, their Decision/Verdict(Catt 2) on the Medical **'Reasons'** leading up to her subsequent failure of Health.

We have highlighted 2 Words-***Treatment***, and ***Reasons***.

Treatment

On release from PHA Queen Alexandria Hospital, she was in good spirits, and had her Family around her with daily visits, as stated by Hants Pol/Medical Panel, "Gosport War Memorial Hospital for **'Rehabilitation'**"(Short TERM stay, not TERMINAL), from her arrival in July, NO member of GWMH Staff suggested that Code A 'Health', would deteriorate and her Condition become 'Terminal'.

Reasons

We as a Family fully understand the difficulties that Nursing Staff and Doctors face and 'Decisions' they take on a daily basis, and these 'Decisions' are also taken by Hospital administrators, eg, 'Supply and Demand of BEDS', was there a 'Admin Regime' to overcome the 'Problem of Bed blocking'?, or are we being 'Facetious' in even suggesting this. Please Advise.

Yours Sincerely-Dated 18th October 2004

Messr's: Code A

Copies to: Alexander Harris(solicitors), Code A H Pol).

Your reference:
Our reference: BFEH/4002044-0131-0
Document number: 80651946_1.doc

Code A

MILLS & REEVE

Urgent

Code A
General Medical Council
Regent's Place
350 Euston Road
LONDON
NW1 3JN

14 October 2004

For the attention of Code A

Dear Code A

Code A

I am enclosing the files that we have received so far from you as promised.

Once again I really do regret that I am not able to deal with this for you. If you find that the medical records have been dispatched to me, let me know and I will make inquiries this end but we have had a look round the post room this morning and we are pretty sure they haven't come in.

Kind regards,

Yours sincerely

Code A

Code A

Mills & Reeve
54 Hagley Road
Edgbaston
Birmingham
B16 8PE

Tel: +44(0)121 454 4000
Fax: +44(0)121 456 3631
DX: 707290 Edgbaston 3
info@mills-reeve.com

MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

Home Address:

Post Code :

Home Telephone No: **Mobile / Pager No:**

E-Mail Address *(if applicable and witness wishes to be contacted by e-mail)*:

Contact Point *(if different from above)*:

Address:

Work Telephone No:

Male ☐ **Female** ☐ **Date and Place of Birth:** Place

Maiden name: **Height:** **Ethnicity Code:**

State dates of witness non-availability:

I consent to police having access to my medical record(s) in relation to this matter	**Yes** ☐ **No** ☐ **N/A** ☐
I consent to my medical record in relation to this matter being disclosed to the defence	**Yes** ☐ **No** ☐ **N/A** ☐
The CPS will pass information about you to the Witness Service so that they can offer help and support, unless you ask them not to. Tick this box to decline their services.	☐

Does the person making this statement have any special needs if required to attend court and give evidence? *(e.g. language difficulties, visually impaired, restricted mobility, etc.).* **If 'Yes', please enter details.**	**Yes** ☐ **No** ☐
Does the person making this statement need additional support as a vulnerable or intimidated witness? If 'Yes', please enter details on Form MG2.	**Yes** ☐ **No** ☐
Does the person making this statement give their consent to it being disclosed for the purposes of civil proceedings *(e.g. child care proceedings)*?	**Yes** ☐ **No** ☐

Statement taken by *(print name)*: Code A

Station: HQ

Time and place statement taken:

Signature of witness: Code A

Signed : Code A ~/1.

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HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

Age if under 18: *(if over 18 insert 'over18')* **Occupation:** Police Officer

This statement (consisting of 11 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature: Code A **Date:** 30TH September 2004.

Tick if witness evidence is visually recorded ☐ *(supply witness details on rear)*

I am Code A of Hampshire Constabulary Code A

Code A and am the senior investigating officer in respect of a police investigation named 'Operation ROCHESTER', an investigation into the circumstances surrounding of death of 88 patients occurring principally during the late 1990's at Gosport War Memorial Hospital, Hampshire.

This investigation followed allegations that during the 1990's elderly patients at Gosport War Memorial Hospital received sub optimal or sub- standard care, in particular with regard to inappropriate drug regimes, and as a result their deaths were hastened.

The strategic objective of the investigation is to establish the circumstances surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service (CPS), to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths.

During the investigation, a number of clinical experts have been consulted.

Signed : Code A Signature witnessed by : _____

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HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

On the 9th November 2000 Code A reported on the death of a patient, Code A

On the 12th February 2001 Code A reported in respect of the deaths of five patients Code A, Code A

On the 18th October 2001 Code A reported on the deaths of patients Code A Code A

The aforementioned reports have all previously been made available to the General Medical Council.

Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths, and concluded that, "a number of factors contributed to a failure of trust systems to ensure good quality patient care".

Between September 2002 and May 2004 the cases of 88 patients including those named above, at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxicology, general medicine, palliative care, geriatrics and nursing.

Signed : Code A Signature witnessed by : _____

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HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

All the cases examined were elderly patients (79 to 99yrs of age) theirs deaths occurring at Gosport War Memorial hospital between January 1996 and November 1999. A common denominator in respect of the patient care is that many were administered Opiates authorized by Code A prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patients concerned, examining in detail patient records, and to attribute a 'score' according to their findings against agreed criteria. A further group of cases were included in this review following a report by Code A, commissioned by the Code A That report is confidential to Code A and may not be discussed further without his agreement.

The team of experts has 'scored' the cases as follows.

Category one- **There were no concerns in respect of these cases upon the basis that 'optimal care' had been delivered to patients prior to their death.**

Category two - **Specific concerns that these patients had received 'sub optimal' care.**

These cases are currently undergoing a separate quality assurance process by a medico legal expert to confirm their 'rating'. Nineteen of these cases that have been 'confirmed', have been formally released from police investigation and handed to the General Medical Council for their consideration. A number of cases

Signed Code A Signature witnessed by : _____

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HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.

Category three **Patient care in respect of these cases has been assessed as 'negligent, that is to say outside the bounds of acceptable clinical practice'.**

The police investigation into these cases is, therefore continuing.

The five experts commenced their analysis of patient records in February 2003. It is anticipated that their work will be finalized in October 2004 as will the quality assurance process by Dr Code A medico legal expert.

As part of the ongoing investigative strategy, since May 2004 a further tier of medical experts, in Geriatrics and Palliative Care have been instructed to provide an evidential assessment of the patient care in respect of in the 'Category three' cases. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service.

At the same time, the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness/suspect interviews, deal with exhibits, complete disclosure schedules, and populate the major crime

Signed : Code A Signature witnessed by : ——

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HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

investigation 'Holmes' system a national police IT application used to record and analyze information relating to serious/complex police investigations.

To date 330 witness statements have been taken and 349 officer's reports created. 1243 'Actions' have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of the Hampshire Constabulary.

Whilst investigations will be fully completed in respect of all of the 'Category three' cases, a small number of sample cases have been selected and work is being prioritized around those with a view to forwarding papers to the CPS as soon as possible by way of expedition. Timescales for this action are clearly dependant upon completion of expert review of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process,

In the event that there is considered a sufficiency of evidence to forward papers to the CPS, it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.

I understand that the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Order Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee.

Signed : Code A

Signature witnessed by : _____

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WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

In my view, this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professionals involved in this enquiry.

Police investigative interviewing operates from seven basic principles, which are laid out in Home Office Circular 22/1992. The first of these being that

"Officers seek to obtain accurate and reliable information from suspects, witnesses or victims in order to discover the truth about matters under police investigation."

Investigative interviewing should be approached with an open mind. Information obtained from a person who is being interviewed should always be tested against what the interviewing officer already knows or what can be reasonably established.

This investigation is currently following various lines of enquiry seeking to establish whether or not any criminal offence has been committed. At present it has not been established that this is the case or in fact whether or not any person is potentially culpable. Once an individual has been identified then decisions have to be made as to what they need to be interviewed about and what information it is proper to disclose to that person prior to their being interviewed.

Decisions as to what the police have to disclose prior to interviews under caution are covered by various aspects of case law, in particular R v Argent (1997). The court commented in this case that the police have

Signed : Code A Signature witnessed by : _____

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

no obligation to make disclosure. In R v Imran and Hussein (1997) the court agreed that it would be wrong for a defendant to be prevented from lying by being presented with the whole of the evidence against him prior to interview.

R v Mason (1987) covers disclosing or withholding information, the process must be justifiable and conducted in the full knowledge of the likely consequences. These consequences could affect not only any subsequent interview but also potentially the whole investigation and any subsequent trial.

Article 6 Human Rights Act deals with the right of an individual facing criminal charge to have a fair and public hearing

Advance disclosure of documentation prior to interviews under caution gives any potential suspect the opportunity to interfere with the interviewing of other witnesses who may have information beneficial to the case.

Furthermore the suspect does not have the opportunity to respond to questioning in an uncontaminated way. They may well respond with answers that they think the police wish to hear. This is unfair to the individual concerned.

Finally early disclosure of material can lead to a suspect fabricating a defence or alibi.

Signed Code A

Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

The Police have an over riding responsibility to conduct an effective and ethical investigation and a have a legal and moral duty to be scrupulously fair to suspects. In addition the police carry an additional responsibility to representing the interests of the victims of crime and society in general. Therefore to provide a guilty suspect with the ability to fabricate a defence around police evidence does not serve those wider interests.

As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case.

I understand that there is a voluntary agreement in place between Code A and the Fareham and Gosport Healthcare Trust of November 2002, the following is a quotation from an e mail message to the investigation from the trust in respect of that matter.

Code A ***has undertaken not to prescribe benzodiazepines or opiate analgesics from the 1st October 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.***

Code A ***will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health-call as a prescription may be required for a 14 day supply of benzodiazepines for bereavement.***

Code A ***also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patient's notes.***

Signed Code A Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A

During a 13month periods from April 2003 Code A ***had written a total of 20 prescriptions all for 2mg diazepam to relatives of deceased and had not prescribed any diamorphine, morphine or other controlled drug.'***

I have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim order committee during September 2002.

Code A - this has been assessed as a category three case and is being investigated accordingly.

Code A - again a category three case.

Code A – Assessed as a category two case by the clinical team, this assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004.

Code A – No further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points;

1. There is no admissible evidence at this time of criminal culpability in respect of any individual.
2. The information adduced by the investigation thus far, and the findings of the experts lead me to have concerns that are such that, in my judgment the continuing investigation and the high level of resources being applied to it are justified.

Signed Code A Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

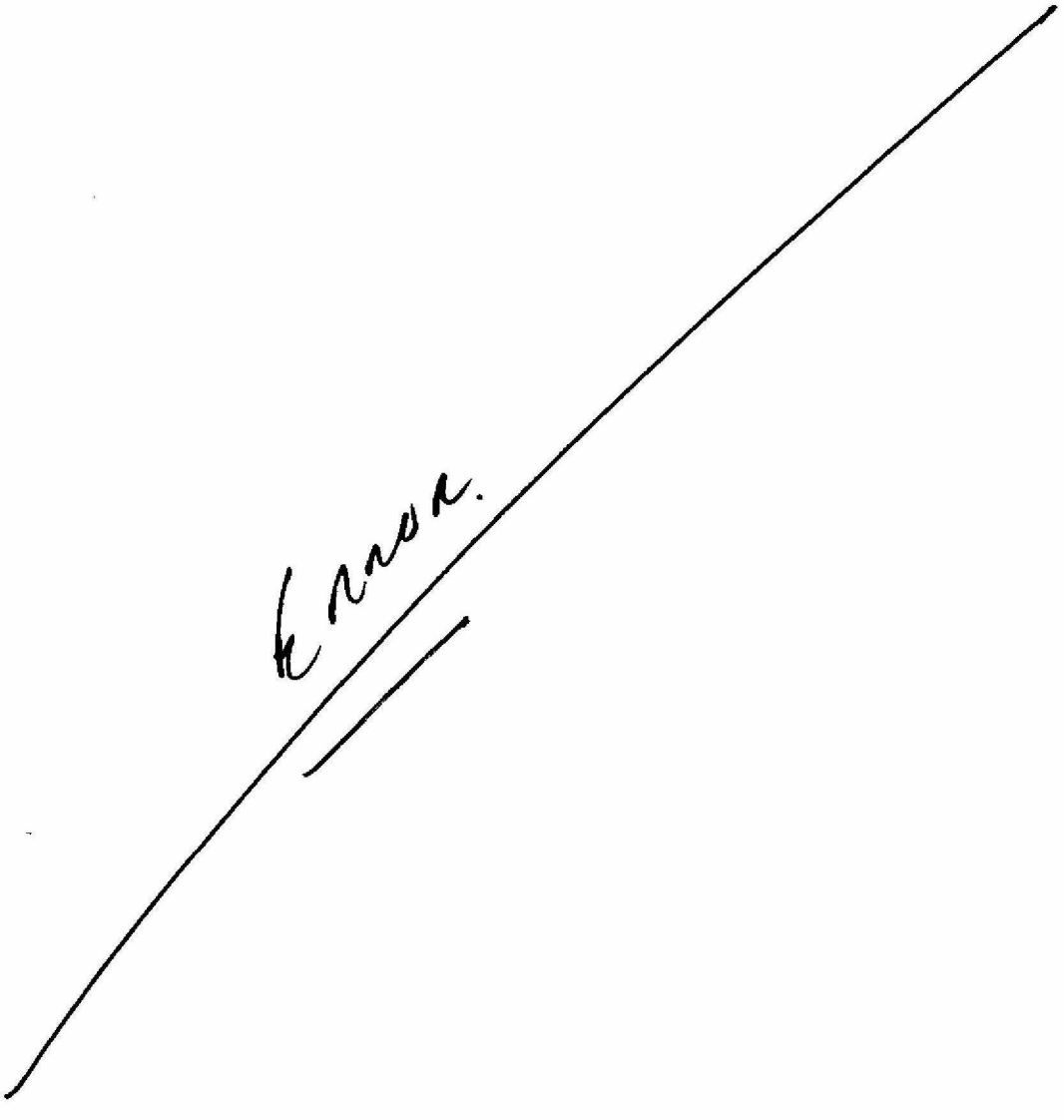
RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

URN //

Statement of : Code A



Code A

S

Signature witnessed by : _____

HAMPSHIRE Constabulary

Code A

CONFIDENTIAL

Our Ref. : Operation Rochester
Your Ref. :

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

Tel: 0845 045 45 45
Direct Dial:
Fax: Code A
Email:

Code A
General Medical Council,
Regents Place,
350,Euston Road,
London.
NW15JE

25 November 2005

Dear Code A

Please find enclosed the contact details for the family group members in relation to the patient files delivered to you on 21st November 2005.
For your information, Code A did not wish for any police action to be taken and Code A Code A had *no concerns about* Code A *'s treatment.*

Yours sincerely,

Code A

DECEASED. FAMILY GROUP MEMBER. ADDRESS.

Code A

Code A

Code A

HAMPSHIRE Constabulary

Code A

CONFIDENTIAL

Our Ref. : Operation Rochester
Your Ref. :

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

Code A
General Medical Council,
Regents Place,
350,Euston Road,
London.
NW15JE

Tel: 0845 045 45 45
Direct Dial:
Fax: Code A
Email: Code A

04 October 2005

Dear Code A

Please find enclosed the contact details for the family group members in relation to the patient files delivered to you on 16th December2004.

I have not includeded the details relating to Code A, they are as follows.

Code A

Yours sincerely,

Code A

CONFIDENTIAL

DECEASED. FAMILY GROUP MEMBER. ADDRESS.

Code A

Code A

Code A

ipcc independent police complaints commission

21 October 2005
For Immediate Release

IPCC Publically apologises to six complainants

The Independent Police Complaints Commission has today issued an apology to six complainants, who complained in 2002 about an investigation by Hampshire Police.

The complaints were against the investigation by Hampshire Police of allegations of unlawful killing against Gosport War Memorial Hospital. The case was inherited by the IPCC from the Police Complaints Authority when it was set up on 1 April 2004.

I[redacted] Code A said: "The usual high standards that the Commission has set itself have not been applied in this case and I wish to publicly apologise to the complainants for that.

"There have been a number of problems with the way that this case has been handled, not least the unacceptable length of time it has taken.

"I have also today offered to meet with all the complainants with IPCC Code A who has recently been given responsibility for this case.

"We will assure the complainants that the IPCC will now move quickly to deal with their complaints.

"Code A will also be reviewing the handling of this case."

-ends-

Notes for editors

- The IPCC is the body with overall responsibility for the police complaints system in England and Wales. It has the task of increasing public confidence in the system and aims to make complaints investigations more open, timely, proportionate and fair. The 17 IPCC Commissioners guarantee the independence of the IPCC and by law can never have served as police officers.
- Since April 1 2004 the IPCC has used its powers to begin 62 independent and 222 managed investigations into the most serious complaints against the police. It has also set new standards for police forces to improve the way the public's complaints are handled. Since 1 April 2004 it has upheld 363 appeals (out of 1102 valid appeals) by the public about the way their complaint was dealt with by the local force.
- The IPCC is committed to getting closer to the communities it serves. It has regional offices in Cardiff, Coalville, London and Sale plus a sub office in Wakefield. Commissioners are regionally based and supported by 84 independent investigators, as well as case workers and specialist support staff.
- The IPCC web site is constantly updated at www.ipcc.gov.uk or members of the public can contact the IPCC on 08453 002 002.

For further information please contact:

Code A

Code A

From: Code A
Sent: 15 Mar 2004 15:52
To:
Subject: Code A

Code A

Thank's for this. Could you chase up Code A in relation to her writting the letter I wanted to send to the police.

Thanks

Code A

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Code A
To: Code A
Code A
Sent: Mon Mar 15 15:16:00 2004
Subject: Code A

Code A

I have checked the Code A files to ascertain what we know about Code A having made a voluntary undertaing not to prescribe opiates and benzodiazepines. From our information, it does not appear that she is subject to any undertaking at present, although she has been in the past, as follows:

We have a copy of a letter from Code A of the Health Authority, to Code A, dated 13 February 2002, in which it is noted that Code A and Code A had agreed on 12 February 2002 that she "would voluntarily stop prescribing opiates and benzodiazepines with immediate effect" and that "We were unable to put a timescale on these restrictions but agreed to review the situation monthly." On 21 March 2002 Code A Code A confirmed to IOC under oath that she was "not prescribing any opiates or benzodiazepines at the moment".

At IOC in September 2002 Code A's counsel informed the Committee that Code A "continues to work full time as a GP subject to other matters. She does not routinely prescribe benzodiazepines or opiates." Counsel then referred to the condition Code A Code A had previously agreed with the Health Authority and said that the HA had lifted the condition. He then noted that that was the only change in Code A's circumstances since March 2002.

We have had not information on this prescribing point since the last IOC meeting in September 2002.

However I have recently clarified with Fareham and Gosport PCT Code A's relationship with the Gosport War memorial Hospital. They have confirmed that Code A Code A was never an employee of the hospital, but that her GP practice is part of a bed fund (enabling local GP practices to admit their patients for appropriate care, supervised by the GP and paid for by the PCT. Approximately 19 months ago Code A agreed voluntarily not to admit patients to the hospital nor supervise any patients n the hospital, and this is the current position.

I will confirm to the police that Dr Barton has not made any voluntary undertaking to the GMC.

Code A