FFW/88/01

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

GMC ORIGINAL PAPERS

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

GMC ORIGINAL PAPERS

1

5352049 v1

General Medical Council	
Original was a Photocopy	✓
Original was Poor Quality	
Date rec for scan	- 2 FEB 2016
Original has been Photocopied to improve Scan Quality	
Document had physical objects ref:	
FFW/88/01	

2000/2047

HAMPSHIRE CONSTABULARY

v

DR JANE BARTON

Volume 1 (of 2)

Dr Barton
GMC Files Reviewed by KVK on 12/02/07

2000/2047 Hampshire Constabulary v Dr Jane Barton, Volume 1 (of 2)

Document	Relates to
Screening decision form	
Letters from Hampshire Constabulary to GMC re allegations of unlawful killing	Gladys Richards
Witness Statement of Lesley Lack dated 31/01/00	Gladys Richards
Witness Statement of Gillian Mackenzie dated 06/03/00	Gladys Richards
Letter from GMC to Dr Barton inviting her to appear before IOC on 21/06/01	Gladys Richards
Letter from GMC to Dr Barton confirming IOC determination that not necessary to impose conditions	Gladys Richards
Note that Dr Barton will not be charged in relation to Gladys Richards' death. Police will be investigation another 9/10 suspicious deaths.	Various
Letter from police to GMC (06/02/02) confirming no further police investigations are appropriate unless further substantial evidence becomes available	Various
Police statement of Dr Barton	Gladys Richards
Expert report of Professor Ford	Richards, Cunnigham, Wilkie, Wilson, Page
Expert report of Professor Livesley	Gladys Richards
Expert report of Dr Mundy	Cunnigham, Wilkie, Wilson, Page
Letter from GMC to Dr Barton inviting her to appear before IOC on 21/03/02	
Transcript of IOC hearing on 21/03/02 - no order made	
Letter of complaint from Bernard Page to GMC (17/05/02) re death of his mother	Eva Page
Letter from Gillian MacKenzie to GMC re concerns regarding conduct of medical staff	Gladys Richards
Letter from Charles Farthing to GMC re death of his step father, Mr Cunnigham	Arthur Cunnigham
Letters from Iain Wilson to GMC re death of his farther,	Robert Wilson

Robert Wilson	
Letter from GMC to Dr Barton informing her of PPC on 29-30/08/02	Page, Wilkie, Richards, Cunningham, Wilson
Investigation into the Portsmouth Healthcase NHS Trust Report	
Dr Barton's written response to PPC allegations	Page, Wilkie, Richards, Cunningham, Wilson
Sub File: 2002/1608 CHI v Unknown:	
Letter from Mrs Batson to PCT complaining of care of mother, Mrs Valma Gilbertson	Velma Gilbertson
Response from PCT to Mrs Batson	Velma Gilbertson

Annex A

Investigation Instruction Sheet (IIS)

Post Preliminary Proceedings Committee Case

Section A – to be completed by the GMC

Priority Band:
C (normal caseload)

1. Date of instructions to solicitor:	27/08/03
1. Name of doctor:	LYNCH, Christopher Balogun
2. GMC file number:	2003/0115; 2000/0643
3. Name of GMC CW: Direct line	Linda Quinn 020 7344 4700
4. Type of case:	Conduct
5. Date for instructed solicitor to complete Section B (one week from the date of these instructions):	27/08/2003
6. Other comments:	London Case 2002/0707 which forms part of the papers was not referred forward. There are 2 complaints going forward - we have so far received agreement from one complainant to use our solicitors

Section B – to be completed by the instructed solicitor within one week of the date of these instructions.

7. Name of investigator:	Adrian Bever
8. Estimated number of witnesses:	7
9. Class of case (1-5, see protocol):	3
10. Target date for completion (see protocol):	19th November 2003
11. Earliest date case may be listed (taking into account the Carlile protocol):	7th April 2004
12.Listing comments:	
13. Date IIS submitted by solicitor:	8th September 2003

Michael Keegan Assistant Registrar
Conduct Case Presentation Section FPD
General Medical Council
178,Great Portland Street
London W1W 5JE

Dr JA Barton
Code A

Your Reference MK/2000/2047

14th September 2002

Dear Sir,

Conduct Case Presentation Section FPD

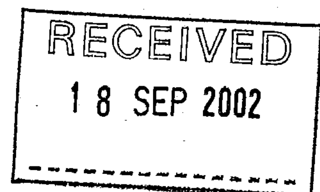
I acknowledge receipt of the letter reference quoted above.

I will be unable to attend a hearing between the dates 11th-22nd December 2002 as I have a holiday booked at that time.

Yours Faithfully

Code A

Dr Jane Barton



Code A

Code A

Medical Screening Memo: Dr Malcolm Lewis

Case: 2000/2047
Doctor: Barton
Date: 11th June 2001

The allegations made in the statement of Lesley Lack raise issues of SPM. The allegation is that a decision was made to treat a post-operative haematoma by palliative pain relieve with use of a morphine syringe driver. There was no further plan to approach the problem by a surgical review. This approach would seriously test the boundaries of the doctrine of 'double effect' and I note that Hampshire Constabulary are pursuing an inquiry of unlawful killing.

The case must be heard at PPC, but should initially be tested at IOC, in view of the seriousness of the allegations.

Code A

Memorandum

Out	Back

Ref: 2000/2047
To: Dr Lewis

From: Jackie Smith
Code A

Date: 12 June 2001

Information received from Hampshire Constabulary concerning Dr Jane Ann Barton (1587920) BM BCh 1972 Oxford

1. We received information from Hampshire Police last July stating that they were investigating the death of Gladys Richards at the Gosport Warn Memorial Hospital.

2. We have now received further information from the police, and I would ask you to consider whether this case meets the threshold for referral to the IOC.

Code A

12/06/01

I asked Dr Lewis to screen this case on the basis of the information provided to us by the police dated 6/6/01. Dr Lewis returned the file to me, after screening, and said that he had screened the case on the basis of what was provided by the police on 6/6/01.

Code A

12/06/01

File note of telephone conversation.

I had a lengthy conversation with Dr Arthurs at RO about Dr Barton. She said she wanted to provide a further briefing to ministers about the case. I said that I had no further information from that which I gave Mike Gill a couple of weeks ago. I stressed that we were awaiting information from the police, and that once received, we would seek a screener's view on whether it met the threshold for referral to IOC. I reiterated that much of the information we had was strictly confidential and that as far as we knew the police was still limiting their investigations to 1 suspicious death. I said that we would keep her fully informed as and when further information became available.

Code A

Jackie Smith
22 May 2001.

Isabel asked me to ring the police to find out the outcome of the meeting scheduled for 21/5/01. I rang Det Supt. Ray Burt (25/5) who was unavailable but I left a message for him to contact me.

Code A

Mi^hael Hudspith Code A

From: Michael Hudspith Code A
Sent: 29 May 2001 13:38
To: Isabel Nisbet Code A
Cc: Gerry Leighton Code A Jackie Smith Code A
Subject: Dr Jane Barton

Further to our conversation on Friday about Dr Barton, Det Supt Ray Burt contacted me this morning. He was unavailable on Friday and I had left a message on his ansaphone.

This current position is as follows:

So far there is one allegation agains t Dr Barton which relates to the death of a Mrs Gladys Richards. A case file has bee prepared and is currently with the CPS. The story of Mrs Richards' received coverage in the local press which prompted other people to bring concerns to the attention of the police.

The outcome of the meeting on Monday was that there was a probability that the police inquiry would be widened to incorporate examination of other similar deaths although this is reliant on other factors such as the CPS's opinion on the death of Gladys Richards. This information was provided strictly **off the record**.

The Force Solicitor, Mike Woodford, is apparently liasing directly with Kathy Tormann at FFW. The police are apparently now in a position to release to us information which has already been disclosed to Dr Barton under caution. The police will be writing to us this week.

Finally, responsibility for the handling of this case has now been passed to Det Supt John James. Should we have any further queries we are to contact either Det Supt James or the force solicitor, Mike Woodford.

I hope this is helpful.

Mike Husdpith

Jackie Smith (7344 3753)

From: Isabel Nisbet [Code A]
Sent: 15 May 2001 15:16
To: Jackie Smith ([Code A]
Cc: Gerry Leighton [Code A] Sarah Bedwell [Code A] Stephanie Day [Code A]
Subject: RE: Dr Jane Barton - 2000/2047

Jackie:

OK.

Isabel

-----Original Message-----
From: Jackie Smith [Code A]
Sent: 15 May 2001 13:58
To: Isabel Nisbet ([Code A]
Cc: Gerry Leighton [Code A] Sarah Bedwell [Code A] Stephanie Day [Code A]
Subject: RE: Dr Jane Barton - 2000/2047

Isabel

The police would not be willing for us to disclose even the suggestion of a possible meeting with relatives, partly because the decision to widen the investigation is one for the ACC, but mainly because they don't want anyone to know at this stage that the investigation may be widen. They fear this could potentially damage their investigation.

Jackie

-----Original Message-----
From: Isabel Nisbet ([Code A]
Sent: 15 May 2001 13:41
To: Jackie Smith [Code A]
Subject: RE: Dr Jane Barton - 2000/2047

Jackie:

Thanks. Can we tell anyone at DH that we were told that there would probably be a meeting with relatives on Monday?

Isabel

-----Original Message-----
From: Jackie Smith ([Code A]
Sent: 15 May 2001 13:33
To: Isabel Nisbet [Code A]
Cc: Gerry Leighton [Code A] Sarah Bedwell [Code A]; Stephanie Day ([Code A]
Subject: RE: Dr Jane Barton - 2000/2047

Isabel

1) The police are not willing for us to disclose to anyone the fact that they will be widening their investigation. The meeting planned for Monday with relatives will take place with the Assistant Chief Constable of Hampshire Constabulary who will ultimately decide whether to widen the investigation, however, DCI Burt is certain that it will happen.

2) The HA is aware of the investigation to date, and have, I understand, cooperated with the police.

3) It would appear that our letter requesting disclosure has gone astray. The police have asked us to fax a further copy this afternoon as they are anxious to provide us with the same information and support as the UKCC, who will also be faxing a letter this afternoon. As soon as we have disclosure from the police (which I anticipate will be no later than close of play on Monday) I will prepare the case for immediate screening. I will also alert Richard to the fact that we may have a possible IOC referral.

Jackie

-----Original Message-----
From: Isabel Nisbet (7915 3575)
Sent: 15 May 2001 13:00
To: Jackie Smith (7344 3753)
Cc: Stephanie Day (7915 3508); Gerry Leighton (7915 3519); Sarah Bedwell (7915 3618)
Subject: RE: Dr Jane Barton - 2000/2047

Jackie:

Many thanks. Three questions:

1) Can we tell DH (at any level) what the police told you? (we have already alerted them to the potential high profile of the case) ?

2) Do we know whether the HA (?N & Mid Hants) are aware? I understand that Dr Barton is chair a PCG)

3) What is our plan with regard to the possibility of referring Dr Barton to the IOC?

Isabel

-----Original Message-----
From: Jackie Smith [Code A]
Sent: 15 May 2001 12:25
To: Gerry Leighton [Code A] Sarah Bedwell [Code A]
Cc: Isabel Nisbet [Code A] Stephanie Day [Code A]
Subject: FW: Dr Jane Barton - 2000/2047
Importance: High

The police called this morning to update us on developments. They have had a meeting with Liz McNulty from the UKCC this morning and disclosed to her the same information they disclosed to us, verbally that is.

The CPS have requested a case conference with the police and Senior Treasury Counsel, however, the police have declined the request at this stage, and instead decided to investigate 9 other suspicious deaths. They plan to go about this by meeting on Monday 21 May 2001 with the relatives of those who died and who have already alerted the police to their concerns. The police will thereafter conduct a rapid investigation and seek a further opinion from Professor Livesley. Although the police are still very keen to keep the matter out of the press, it may prove much more difficult to do once they have their meeting on Monday.

We still await formal disclosure from the police of certain documentation but I have no reason to think that it will not be forthcoming.

We will be speaking to the police again after Monday.

Jackie

-----Original Message-----
From: Jackie Smith ([Code A]
Sent: 03 May 2001 12:31
To: Gerry Leighton ([Code A] Sarah Bedwell [Code A]
Cc: Isabel Nisbet [Code A] Stephanie Day (7915 3508); Chief Executive [Code A]
Subject: Dr Jane Barton - 2000/2047
Importance: High

I had a meeting with DCI Burt at Winchester Police Station yesterday regarding Dr Barton.

The following information has been given to us by the police in strict confidence and cannot be disclosed to a third party. If it is felt that we need to disclose it to any other party, please could we meet beforehand to discuss our strategy.

Dr Barton is a GP who is under investigation by police for the unlawful killing of 91 year old patient. In July 1998, Mrs Richards, was admitted to the Gosport War Memorial Hospital following a problem with her hip. Mrs Richards died in August of that year. Dr Barton signed the death certificate and certified that Mrs Richards died of pneumonia. The daughters of the deceased were unhappy about their mother's death and complained to police. An investigation was carried out and the CPS advised that there was insufficient evidence to charge. The daughters complained to the Police Complaints Authority who ordered the police to reinvestigate. DCI Burt carried out a "proper" investigation and he had submitted a file to the CPS for advice.

The police told us yesterday, in strict confidence, that have obtained an expert opinion from Professor Brian Livesley, an expert in the field of geriatric care. The police would not allow us to have a copy of Professor Livesley's report, however, they did allow us sight of his conclusions. He concluded, without doubt, that Dr Barton and three nurses at the Gosport War Memorial Hospital was responsible for the unlawful killing of Mrs Richards by injecting her with diamorphine. The police described the culture on the ward that Mrs Richards was on as "institutionalised euthanasia".

The police also informed us that following their investigation, 10 other people have come forward expressing concern about care/treatment of relatives at the hospital. A former nurse has also provided the police with a statement detailing the type of culture in existence at the time of Mrs Richards' death.

The police are currently awaiting advice from Senior Treasury Counsel and expect to receive a decision from the CPS, based on that advice, within the next 4/6 weeks. They said that if the CPS advise that there is sufficient to charge Dr Barton and the 3 nurses named, they will most likely have to consider investigating around **950 deaths.**

There is significant interest locally from the press, but some national newspapers have also

shown an interest. The police are very keen to keep a lid on things at the moment, particularly given the scale of the investigation if Dr Barton is charged. They have asked that our line to a inquirers should be: we are working closely with the police.

The force Solicitor, who was also present at the meeting, has agreed to provide us with Mrs Richards' medical notes, the statements of Mrs Richards' two daughters and Dr Barton's prepared statement which she gave to police. Dr Barton has so far refused to answer any questions. The police have also agreed to provide us with a letter stating that they are investigating the death and that the file is with the CPS advice. I believe that this would be sufficient for our purposes, at this stage, for the screener to decide whether the case meets the threshold for an IOC referral. We hope to get the material from the police next week.

I would be grateful if Isabel could advise me whether she thinks we should contact the UKCC and if so, to who I should make contact. I will, of course, let RO know that the police are investigating the matter but will not, at this stage, go into detail about their investigation.

Jackie

File note of telephone conversation.

I spoke with Regional Director of Public Health, Dr Mike Gill, and informed him, in outline only, of the developments and promised to keep him updated.

He said that Dr Yvonne Arthurs was dealing with the matter, and her number is 020 Code A

Code A

Jackie Smith
10 May 2001.

J...kie Smith Code A

From: Isabel Nisbet Code A
Sent: 10 May 2001 11:24
To: 'Liz McAnulty'
Cc: Sarah Bedwell Code A Jackie Smith Code A
Subject: RE: Robin Herron

Liz:

Our contact here is Jackie Smith Code A Otherwise, speak to Sarah Bedwell (Code A The police are very cagey about how much can be said (NB NO disclosure to the doctor yet, on police instructions). The numbers which Robin mentioned were in local press reports.

Isabel

-----Original Message-----
From: Liz McAnulty Code A
Sent: 09 May 2001 15:44
To: ' Code A
Subject: Robin Herron
Importance: High

Dear Isabel
I've just had a meeting with Robin (what a nice man!). He said you had contacted him about a doctor who may have been involved with a large number - possibly 600 - premature patient deaths. He said the police had been in contact with us as there were wider issues, possibly involving nurses. Do you have a contact I can get in touch with as we don't seem to have heard anything yet.

Best wishes

Liz

020 7333 - 6548.
43

Jackie Smith (7344 3753)

From: Jackie Smith (7344 3753)
Sent: 03 May 2001 12:31
To: Gerry Leighton (7915 3519); Sarah Bedwell (7915 3618)
Cc: Isabel Nisbet (7915 3575); Stephanie Day (7915 3508); Chief Executive (7915 3564)
Subject: Dr Jane Barton - 2000/2047

Importance: High

I had a meeting with DCI Burt at Winchester Police Station yesterday regarding Dr Barton.

The following information has been given to us by the police in strict confidence and cannot be disclosed to a third party. If it is felt that we need to disclose it to any other party, please could we meet beforehand to discuss our strategy.

Dr Barton is a GP who is under investigation by police for the unlawful killing of 91 year old patient. In July 1998, Mrs Richards, was admitted to the Gosport War Memorial Hospital following a problem with her hip. Mrs Richards died in August of that year. Dr Barton signed the death certificate and certified that Mrs Richards died of pneumonia. The daughters of the deceased were unhappy about their mother's death and complained to police. An investigation was carried out and the CPS advised that there was insufficient evidence to charge. The daughters complained to the Police Complaints Authority who ordered the police to reinvestigate. DCI Burt carried out a "proper" investigation and he had submitted a file to the CPS for advice.

The police told us yesterday, in strict confidence, that have obtained an expert opinion from Professor Brian Livesley, an expert in the field of geriatric care. The police would not allow us to have a copy of Professor Livesley's report, however, they did allow us sight of his conclusions. He concluded, without doubt, that Dr Barton and three nurses at the Gosport War Memorial Hospital was responsible for the unlawful killing of Mrs Richards by injecting her with diamorphine. The police described the culture on the ward that Mrs Richards was on as "institutionalised euthanasia".

The police also informed us that following their investigation, 10 other people have come forward expressing concern about care/treatment of relatives at the hospital. A former nurse has also provided the police with a statement detailing the type of culture in existence at the time of Mrs Richards' death.

The police are currently awaiting advice from Senior Treasury Counsel and expect to receive a decision from the CPS, based on that advice, within the next 4/6 weeks. They said that if the CPS advise that there is sufficient to charge Dr Barton and the 3 nurses named, they will most likely have to consider investigating around **950 deaths.**

There is significant interest locally from the press, but some national newspapers have also shown an interest. The police are very keen to keep a lid on things at the moment, particularly given the scale of the investigation if Dr Barton is charged. They have asked that our line to any inquirers should be: we are working closely with the police.

The force Solicitor, who was also present at the meeting, has agreed to provide us with Mrs Richards' medical notes, the statements of Mrs Richards' two daughters and Dr Barton's prepared statement which she gave to police. Dr Barton has so far refused to answer any questions. The police have also agreed to provide us with a letter stating that they are investigating the death and that the file is with the CPS advice. I believe that this would be sufficient for our purposes, at this stage, for the screener to decide whether the case meets the threshold for an IOC referral. We hope to get the material from the police next week.

I would be grateful if Isabel could advise me whether she thinks we should contact the UKCC and if so, to who I should make contact. I will, of course, let RO know that the police are investigating the matter but will not, at this stage, go into detail about their investigation.

Jackie

File Note: 2000/2047

(Stephanie Day enquired about this case following a call from the press asking about this doctor.) I rang DCI Burt who gave the following summary of the investigation:

Gladys Richards died 21 August 1998 at Gosport War Memorial Hospital (has facilities for elderly, no resident doctors, care provided by external GPs etc). Ms Richards had returned to the hospital for the second time to recuperate from a further fall (the first time involved a broken hip).
In September 1998, one of her daughter's raised allegations of unlawful death and the matter was referred to local police in Gosport, who concluded their investigation in March 1999, having found a lack of evidence to support the allegations. The daughter complained to the Police Complaints Authority and the matter was referred to DCI Burt in mid-1999 to be re-examined.
Dr Barton and various nurses were interviewed under caution, medical records were obtained along with an expert opinion. The case was passed to the CPS and DCI Burt will be chasing them tomorrow for a progress report/decision.

I explained our IOC powers and the information we need asap to determine whether interim orders should be considered. DCI Burt understood the need to act quickly and I agreed to fax my request so that he can refer it on if necessary. He would also be happy for us to visit and go through their paperwork. I asked him about the press cuttings which refer to other similar allegations. He confirmed that they have received several enquiries but have not yet instigated any further investigations and are unlikely to do so until they are notified of the CPS' decision in the original case. It is also unclear as yet whether the other concerns relate to the same doctor.

Contact details:
DCI Ray Burt
Hampshire Constabulary
Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB
Tel: 0845 045 45 45
Fax: 01962 871130

Suki Sanghera, 11 April 2001

Stephanie Day has spoken to the Police Media Services Dept., who believe that Dr Barton has recently left her job, but we have no further details.
SS 11/4.

Update Doctor Details for Case 2000/2047

Doctor Complainant Help

Reg. Number	Surname	Forenames
1587920	Barton	(Mrs) Jane Ann

Salutation	Sex	Full Regn. Date	Date of Birth	Ethnic origin	Country of Qualification
Dr	Female	07/01/1974	19/10/1948		UK

Registered Qualifications: BM BCh 1972 Oxfd

Erasure Code:

Address:
11 Village Rd,
Alverstoke,
Gosport,
Hampshire

Post Code: PO12 2LD

Specialty: General Practice

Sub-specialty: General Practice

More

Field of Practice: GP

Grade:

Identity Confirmed: Medical Directory

Alarm Code: ☑ Set

Last Updated
Date: 31/07/2000
By: WBANNIST

Update Exit

Start | NAT... | Fitn... | Micr... | Micr... | Insid... | Folio... | TER... | 16:13

No pps
WB 31/7/00.

Screening decision form
Section 4

Assessing Risk and IOC referral

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

FPD complaint reference 2000 2047

Date 1 2 0 2 0 2 (D D M M Y Y)

Dr's name BARTON

Reg no 1587920

Complainant

Q4.1 Regardless of the state of the information received so far, in your opinion does the doctor appear to be:

Tick all that apply

a. A current or imminent risk to the public or patients? Yes ☑ →Q4.2

b. At risk if s/he continues to practise unrestricted? Yes ☑ →Q4.2
and/or

c. Does it appear to be contrary to the public interest for the doctor to continue practising unrestricted while the current issues are investigated? Yes ☐ →Q4.2

None of the above ☐ →*Sign and date. Return to the office*

Q4.2 What is the risk?

Tick only the main option
Evidence that doctor:

- Is suffering from a communicable disease ☐
- Appears to have been misled by a patient into acting against the patient's best interest (e.g. prescribing substantial amounts of controlled drugs) ☐
- Is being investigated or has been convicted of a serious criminal offence and public confidence in the profession will be seriously damaged if s/he continues to practise ☐
- Appears to have a level of skill/knowledge seriously below that expected and such that s/he poses a potential risk to patients ☐
- Appears to have caused serious harm to a patient(s) and may repeat this ☑

} Q4.3

Other, please specify ☐

....

....

Q4.3 Should the IOC be asked to consider making an interim order?

Yes ☑ →Q4.4

No ☐ →Please give brief reasons. Sign & date and return to the office

Please specify reasons ....

....

Q4.4 In your opinion, on what basis should the IOC consider making an order

Tick all that apply

a. In the doctor's own interests ☐
b. Protection of the public ☑
c. Preserving public confidence in the profession ☐

Sign & date and return to the office

Signed (Medical Screener) **Code A**

Date 14/2/02

Screening decision form
Section 5
SPM or SDP

Completed by the Office (categorise) and the Medical Screener (judgement)

FPD complaint reference 2000 2047 Date 12 02 02 (D D M M Y Y)

Dr's name BARTON Reg no 1587920 Complainant

Q5.5 MUST BE COMPLETED BY THE MEDICAL SCREENER FOR ALL CASES UNLESS AN EARLIER REFERRAL TO IOC WAS AGREED

Q5.1 Did the events complained take place after 1 July 1997?

- Yes ❑ *Could be spm or sdp*
- No ❑ *Cannot be sdp may be spm*
- Combination ❑ *Could be spm or sdp*

→Q5.2a

Q5.2a Does the complaint fall into any of the following categories which raise an issue of spm?

SPM
Tick all that apply

	Office	Medical Screener
Sexual assault or indecency		
Indecent behaviour	❑	❑
Indecent assault	❑	❑
Rape/attempted rape	❑	❑
Female circumcision	❑	❑
Violence		
Assault/breach of the peace	❑	❑
Attempted murder	❑	❑
Firearms offences	❑	❑
Murder/manslaughter	❑	❑
Robbery	❑	❑
Dysfunctional conduct		
Improper sexual/emotional relationship	❑	❑
Offences under the Abortion Act	❑	❑
Persisting in practice when carrier of an infectious disease	❑	❑
Controlled substance offences	❑	❑
Dishonesty		
False claims to qualifications/experience	❑	❑
Financial fraud/deception	❑	❑
Forgery/improper alteration of documents	❑	❑
Research misconduct	❑	❑
Theft	❑	❑

→Q5.5

None of the above apply	❑	❑	→ Q5.2b

Q5.2b The following categories might raise an issue of spm and/or suggest there may have been sdp.

Office: Tick all categories that apply
Medical Screener: Please make a judgement for each category ticked by the office, And any others that you judge appropriate.

- SPM is action or inaction by a doctor of a serious kind of which no doctor of reasonable skill and exercising reasonable care would be responsible. The weight of the evidence and the intent of the doctor should not be taken into account when reaching a decision on whether a question of SPM is raised at this stage
- SDP is normally indicated by a pattern of serious failure to comply with relevant professional Standards. When deciding whether a complaint raises an issue of sdp, evidence before 1 July 1997 cannot be taken into account.

Tick all that apply

	Office	Medical Screener	
Dysfunctional conduct			
Abusive behaviour	☐	☐	
Driving under the influence of alcohol/drugs	☐	☐	
Failure to report dysfunctional colleague(s)	☐	☐	
Soliciting money from patients	☐	☐	
Dishonesty			
False certifications/false reporting	☐	☐	
False claims about effectiveness of treatment	☐	☐	
Sub-standard clinical practice and care			
Communication skills	☐	☐	
Confidentiality issues	☐	☐	
Consent issues	☐	☐	
Inadequate practice arrangements	☐	☐	
Inappropriate/irresponsible prescribing	☐	☑	
Practising beyond limits of skills or knowledge	☐	☐	→Q5.2c
Relations with colleagues	☐	☐	
Relations with patients	☐	☐	
Sub-standard treatment	☐	☑	
Other complaints and enquiries			
Administration of nursing/residential homes	☐	☐	
Advertising	☐	☐	
Canvassing of patients/other practice disputes	☐	☐	
Medical reports/records issues	☐	☐	
Removal from practice list	☐	☐	
Treatment under the Mental Health Act	☐	☐	
Other *(please specify)*	☐	☐	
None of the above apply	☐	☐	→ Q5.2c

To be completed by the Medical Screener

Q5.2c The following criteria may assist in assessing whether the conduct or performance procedures are appropriate. This list is not exhaustive but may be an indicator of sdp.

Tick all that apply

A doctor who has a tendency to use inappropriate techniques	☐	Q5.3
A lack of basic knowledge/poor judgement	☐	
A lack of familiarity with basic clinical/administrative procedures	☐	
A doctor who has failed to keep up to date records	☐	
A lack of insight	☐	

A range of inadequacies:

Outdated techniques	☐	Q5.3
Attitude	☐	
Inadequate practice arrangements	☐	
Concerns over referral rates	☐	
Poor record keeping	☐	
Inadequate hygiene arrangements	☐	
Other (*please specify)*	☐	

Q.5.3 On the basis of information, in your opinion does the case raise an issue of spm or is there a suggestion there may have been sdp?

spm	☑	Refer to next PPC	→Q5.5
sdp	☐	Send performance Rule 5 letter	→Q5.5
both	☐		→Q5.5
cannot judge	☐		→Q5.4

Please give brief reasons for your decision Evidence of repeated prescribing pattern that is described as inappropriate & dangerous.

To be completed by the Medical Screener

Q5.4 If you cannot make a decision on the information currently available, from whom is further information required and **what** is required?

Tick all that apply		*Write a brief note*	
Complainant	☐	....	→ *Q5.5 then Sign. date and return to the office (to seek further information)*
HA/NHS Trust/PCT	☐	....	
GMC' solicitor's investigation	☐	....	
Other (please specify)		....	
....	☐	....	
....	☐	....	

Signed (Medical Screener) ....

Date ....

Q5.5 Regardless of the state of the information, in your opinion does there appear to be a current or imminent risk to the public?

Yes ☑ → Q5.6 and SDF 4
No ☐ → Q5.6
Already referred. N/A ☐ → Q5.6

Q5.6 Based on the information available to you at this stage, please rate the seriousness of the doctor's alleged behaviour/conduct.

Tick one option only

a.	Very serious	☑	c.	Not very serious	☐	Q5.7
b.	Quite serious	☐	d.	Not at all serious	☐	

Q5.7 Do any of the following exceptions apply?

If multiple options apply, only tick the box for the main option

a. Doctor is terminally ill and not in active practice ☐
b. There is no tenable basis for taking action because:
   i. The complainant has declined reasonable requests for further information ☐
   ii. There is no probative evidence to support the allegation(s) nor any prospect of obtaining any ☐
   iii. The complaint is self-evidently untrue/irrational ☐

c. None of the above apply ☑

→ Q5.8

Declaration

Q5.8a In my view this case raises:

Tick one box only

a. An issue(s) of spm and should be referred to the next available PPC ☑ 10 C.
b. An issue(s) of sdp and a performance Rule 5 letter should be sent ☐

Sign, date below and return to the office

c. Issues of both spm and sdp ☐ → *Q5.8b*
d. No issues of spm or sdp ☐ → *Q5.8c*

Q5.8b In my opinion this case should be considered in accordance with:

Tick one box only

a. The conduct procedures ☑ → Refer to next PPC
b. The performance procedures ☐ → Performance R5 letter

Signed (Medical Screener) ....
Date 14/2/02

OR

Q5.8c In my view this case cannot proceed under either the conduct or performance procedures for the reasons as shown at Q5.7

❑ *Sign. date and return to the office*

Signed (Medical Screener) ....

Date ....

To be completed by the Lay Screener

Q5.9a Do you agree with the Medical Screener's decision at Q5.8?

Yes ❑ → *Sign. date and return to the office*

No ❑ → Q5.9b

Signed (Lay Screener) ....

Date ....

Q5.9b Please state briefly why you do not agree with the Medical Screener's decision at Q5.8

....

....

....

....

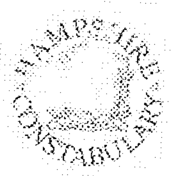
....

Sign, date and return to the office

Signed (Lay Screener) ....

Date ....

2000/2047



HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref : HQ/CID/SE/DCI/2000

Your Ref :

Code A

The Fitness to Practice Directorate
General Medical Council,
178 Great Portland Street,
London,
WIN 6JE.
For the attention of Miss BANNISTER

Referral letter

Private and Confidential

Dear Miss Bannister,

Re: Dr. Jane BARTON G.P.

Further to my telephone call of yesterday's date, I wish to provide brief details of an investigation which is currently being conducted by the Hampshire Constabulary.

An allegation has been made by members of the family of a woman named Gladys RICHARDS to the effect that she was unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital (GWMH) during or about the period 17th-21st August 1998. The doctor who appears to have been responsible for the care of Mrs RICHARDS at the time is Dr. Jane BARTON Code A who is a General Practitioner practising in Gosport, Hampshire. Dr. BARTON is additionally engaged by the Portsmouth Healthcare (NHS) Trust as a visiting Clinical Assistant at the GWMH. Dr. BARTON currently practises at The Code A Hampshire. The investigation is ongoing and no criminal charges have been preferred. Dr. BARTON is represented by Mr. Ian BARKER of HEMSONS (Solicitors) of London.

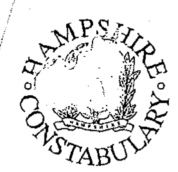
If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Code A

R. J. BURT
Acting Detective Superintendent

2000/2047



HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Code A

The Fitness to Practice Directorate
General Medical Council,
178 Great Portland Street,
London,
WIN 6JE.
For the attention of Miss BANNISTER

Private and Confidential

Dear Miss Bannister,

Re: Dr. Jane BARTON G.P.

Further to my telephone call of yesterday's date, I wish to provide brief details of an investigation which is currently being conducted by the Hampshire Constabulary.

An allegation has been made by members of the family of a woman named Gladys RICHARDS to the effect that she was unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital (GWMH) during or about the period 17th-21st August 1998. The doctor who appears to have been responsible for the care of Mrs RICHARDS at the time is Dr. Jane BARTON Code A who is a General Practitioner practising in Gosport, Hampshire. Dr. BARTON is additionally engaged by the Portsmouth Healthcare (NHS) Trust as a visiting Clinical Assistant at the GWMH. Dr. BARTON currently practises at The Code A. The investigation is ongoing and no criminal charges have been preferred. Dr. BARTON is represented by Mr. Ian BARKER of HEMSONS (Solicitors) of London.

If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Code A

R. J. BURT
Acting Detective Superintendent

Your reference HQ/CID/SE/DCI/2000

In reply please quote **WB/2000/2047**

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

19 September 2000

R J Burt
Acting Detective Superintendent
Hampshire Constabulary
Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire PO2 8BU

Dear Acting Detective Superintendent Burt

Dr Jane Ann Barton

I write regarding your letter of 27 July 2000 notifying the GMC that Dr Barton was under investigation for alleged unlawful killing.

It would be most appreciated if you could update us on the current position of this case and in particular, the outcome of your enquiries. Also please confirm whether the doctor has been charged.

Thank you for your assistance in this matter.

Yours sincerely

Code A

Ms W Bannister
Fitness to Practise
Code A
Fax 020 7915 3642

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Code A

18/09/00

Miss Bannister
The Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

IN CONFIDENCE

Dear Miss Bannister

Re: Dr Jane BARTON G.P.

Further to my previous letter of the 27th July 2000, may I please formally enquire as to whether the General Medical Council are aware of any complaints or allegations made against Dr BARTON which might bring into question professional competence or standards of care.

Yours sincerely,

Code A

R J BURT
Detective Chief Inspector

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Code A

20/09/00

Ms W Bannister
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

IN CONFIDENCE

Dear Ms Bannister,

Re: Dr Jane BARTON G.P.

My letter of the 18/9/00, and yours of the 19/9/00, appear to have crossed in the post.

The investigation is ongoing and a file will be submitted to the Crown Prosecution Service as soon as possible. I would estimate that the outcome is unlikely to be known for at least 3 - 4 months.

Dr BARTON has not been charged with any criminal offence.

Yours sincerely,

Code A

R J BURT
Detective Chief Inspector

Your reference HQ/CID/SE/DCI/2000

In reply please quote **WB/2000/2047**

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

26 September 2000

R J Burt
Detective Chief Inspector
Hampshire Constabulary
Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire PO2 8BU

Dear Detective Chief Inspector Burt

Dr Jane Ann Barton

Thank you for your letters of 18 and 20 September 2000 respectively, the contents of which have been noted.

You wanted to know whether the GMC were aware of any complaints or allegations made against the above-mentioned doctor. I have checked our records and I can confirmed that there has been no complaints made against Dr Barton and she has not appeared before the Professional Conduct Committee.

We shall await your further correspondence in respect of the outcome of investigations relating to this matter.

Yours sincerely

Code A

Ms W Bannister
Fitness to Practise
Code A
Fax 020 7915 3642

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

FITNESS TO PRACTISE DIRECTORATE

CONDUCT & REFERRALS

TELEPHONE MESSAGES

Call taken by: Winnell Bannister	
Date: 30 January 2001	Time: 10:28
Name of caller: DCI Burt of Hampshire Constabulary	Caller's status: (eg MP, patient's mother)
'Phone number of caller: 0845 045 45 45	Address of caller: (if necessary)
Doctor(s) complained/enquired about: Dr J A Barton	If we have file already open - file reference: 2000/2047

Summary of 'phone call:

1. DCI Burt returned my call.
2. The case was sent to the Crown Prosecution Service (CPS) about 2/3 weeks ago.
3. He does not expect to hear from the CPS for a least a month.
4. He will update us on the outcome in due course.

For next action by:

.nnell Bannister Code A

From: Jonathan Inkpen Code A
Sent: 16 March 2001 14:06
To: Winnell Bannister Code A
Subject: FPD/2000/2047 - Dr Barton

DCI Burt called. The papers are with the CPS for advice and they, in turn , have referred the matter to Treasury Counsel for advice. He does not know how long it will be before he has an answer, but he assured me he will provide regular updates.

From personal experience the TC's usually turn their advices around quite quickly but the CPS branches then procrastinate as several "senior management" lawyers get involved in making the final decision. As this matter is being handled by a specialist unit you may be lucky and get a reply within the month.

Jonathan Inkpen

Sarah Bedwell

Sotu
Can you make contact with the Trust as and obtain further details?
Gerry 10/4 G 11/4

Can we find out about this please?

9/4

© DAILY TELEGRAPH
09/04/01

Police look into deaths of elderly at hospital

POLICE investigating an allegation that a 91-year-old woman was unlawfully killed at a hospital are examining the circumstances surrounding the deaths of three more patients.

Relatives of three pensioners came forward after police announced their inquiry into the woman's death.

Detectives have spent two years investigating the woman's death at the National Health Service War Memorial Hospital in Gosport, Hants.

A file has been sent to the Crown Prosecution Service and if the case goes to court the files into as many as 600 deaths of elderly people could be re-opened.

It is thought the three new inquiries will involve concerns over the use of the pain-killing drug diamorphene.

Detectives have interviewed a number of medical staff at the hospital, though there have been no arrests.

One of the relatives in the fresh investigations had protested to the health service ombudsman after his mother, Edna Purnell, 91, died in December 1998.

Her son, Mike Wilson, claimed his mother had fallen into a "trance-like" state before her death.

The ombudsman examined Mr Wilson's complaint against Portsmouth Health-Care NHS Trust but cleared the hospital of any blame.

The ombudsman concluded: "I have not found evidence of unsatisfactory medical or nursing care and am satisfied Mrs Purnell was not given excessive doses of morphine."

But the report criticised the hospital for the way in which some of her medical notes were destroyed.

"The early destruction of the records was contrary to the trust's own policy and went against official guidance," it said. "The trust expressed their deep regret ... and said it was the only time such an error had been made."

Detectives will also scrutinise events surrounding the death at the hospital last September of Jack Williamson, 81, of Gosport.

His son Ian, 48, said he thought it "rather strange" that his father had died days after his mother Ivy, 76.

A widow from Fareham, Hants, has also approached police about her husband's death at the hospital.

THE SUN
09/04/01

COPS PROBE NHS DEATHS

DETECTIVES probing claims that a 91-year-old woman was unlawfully killed at an NHS hospital are investigating three more pensioners' deaths.

Relatives of the trio called cops after learning of their two-year inquiry at the War Memorial Hospital in Gosport, Hants.

A file on the 91-year-old has gone to Crown Prosecutors. If it goes to court, files may re-open into **600** patients' deaths.

It is thought the new inquiries will probe concerns over pain-killing drugs. Hospital chiefs pledged full co-operation.

THE TIMES
10/04/01

Sarah Bedwell

Gerry

→ Jackie. Smith

Police to examine hospital deaths

By Stewart Tendler
Crime Correspondent

POLICE investigating the death of a 91-year-old in a Hampshire hospital are interviewing the families of three other elderly patients who have died there.

A report on circumstances surrounding the death of the woman has been sent to the Crown Prosecution Service.

She died in 1998 in the War Memorial Hospital at Gosport and her family later made a complaint of unlawful killing. The dead woman has never been named.

Last month a detective inspector and a detective constable were criticised for their handling of the case after an internal inquiry supervised by the Police Complaints Authority. Last week relatives of Edna Purnell, also 91, came forward to police after news of the investigation was made public. Mrs Purnell died a few months after the other woman. The son of Jack Williamson, 81, and his wife, Ivy ,76, who died last September, has also complained.

GMC100829-0040

Suki
As discussed Stephanie

OPERATION ROCHESTER

Police have completed their investigation into the circumstances surrounding the death of a 91-year-old woman from Lee on Solent following a complaint by her family.

She died in August 1998 at the War Memorial Hospital in Gosport after being transferred there from Royal Hospital Haslar.

In line with patient confidentiality we cannot reveal the nature of her medical condition.

A file has have been sent to the Crown Prosecution Service and police are awaiting its decision.

We have the full co-operation of the Portsmouth HealthCare (NHS) Trust and the Royal Hospital Haslar for our investigation.

Ends 300301 Pauline Davey Code A

Hampshire Constabulary Media Services
Police Headquarters, Romsey Road,
Winchester SO22 5DB
T: 01962 871619 F: 01962 871194
mediaservices@hampshire.police.uk

www.hampshire.police.uk

Your reference: HQ/CID/SE/DCI/2000

In reply please quote: FPD/2000/2047

11 April 2001

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

First Class: Confidential

DCI Ray Burt
Hampshire Constabulary
Criminal Investigation Department
Police Headquarters
West Hill, Winchester
Hampshire SO22 5DB

Dear Detective Chief Inspector Burt

Dr Jane Ann BARTON Code A

Thank you for the details that you provided during our telephone conversation today.

As you will be aware, the GMC was granted additional powers by Parliament last summer which, in effect, allow us to consider restricting a doctor's registration status, *without prejudice*, at any stage of our proceedings if it is deemed to be in the public interest or the interests of the doctor concerned. All meetings of this new Interim Orders Committee are held in private. It appears that, given the nature of the allegations against Dr Barton, this case may fall into the above category.

Before considering whether an interim order is appropriate in this case we need to be in possession of sufficient information on which to make a fair judgement. To this end I should be grateful if you would furnish us, at your earliest convenience, with a brief case summary, copies of witness statements, transcripts of interviews conducted, copies of the medical expert's report and the relevant medical notes. Any information we consider under these new procedures would naturally be disclosed to the doctor beforehand to allow her to prepare a defence. We understand that Dr Barton has not been formally charged over these allegations and it would therefore be useful if, when disclosing information to us, you could provide an indication of which documents you would permit us to disclose to Dr Barton at this time and therefore use in connection with our proceedings.

We appreciate that when disclosing confidential information you need to balance the rights of privacy of the individual against a necessary need to protect the public. However, given both the nature of the allegations against Dr Barton and her public position, we feel our request for information is reasonable and relevant.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

If you would find it helpful to meet to discuss these matters further, we would be happy to do so at your earliest convenience.

Thank you for your assistance. I look forward to hearing from you.

Yours sincerely

Code A

Ms Suki Sanghera
Fitness to Practise

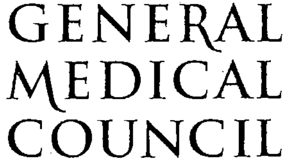
Code A

Your reference

In reply please quote Code A

Please address your reply to Fitness to Practise Directorate
Fax 020 7915 3642

20 April 2001



Protecting patients, guiding doctors

First class: Confidential

DCI Ray Burt
Hampshire Constabulary
Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB

Dear DCI Burt

Dr Jane Ann BARTON

I am writing further to recent correspondence and telephone conversations with my colleague, Suki Sanghera.

I have now taken conduct of this matter and would appreciate it if you could contact me so that we can arrange a mutually convenient time to meet to discuss matters. We are happy to visit you, if this would be more convenient. I wonder whether the week commencing 30 April 2001 would be convenient to you?

I look forward to hearing from you.

Yours sincerely

Code A

Jackie Smith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Our Ref. : HQ/CID/DCI 7410/2001

Your Ref. :

Code A

23 April 2001

Jackie Smith
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE

CONFIDENTIAL

Dear Jackie,

Dr. Jane Ann Barton

I write with reference to our telephone conversation, today, and the letter that I received from your colleague Suki Sanghera, dated of the 11th April 2001.

I confirm that I have referred the matters raised to Mr. P. Close of the Casework Directorate, Crown Prosecution Service, 50 Ludgate Hill, London EC4M 7EX.

You advised me, today, that you have spoken to Mr Close and that he confirmed that he has sought counsel's opinion as regards the disclosure of information to yourselves.

I look forward to meeting you at Police Headquarters, Winchester on Wednesday 2nd May 2001 at 1200 hours.

Yours sincerely,

Code A

R.J. Burt
Detective Chief Inspector

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	1726
CONNECTION TEL	901962871130
SUBADDRESS	
CONNECTION ID	
ST. TIME	15/05 14:24
USAGE T	01'06
PGS.	3
RESULT	OK

Fax

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

To	DCI Ray Burt
Fax number	01962 - 871130
From	Jackie Smith
Direct Dial	**Code A**
Direct fax	
No. of pages (inclusive)	3
Time	14:20
Date	15 May 2001

Dear DCI Burt

Further to our telephone conversation earlier today, please find enclosed a copy of the letter sent to Mike Woodford.

If you require any further information, please do not hesitate to contact me.

Kind regards.

Jackie Smith

178 Great Portland Street London W1W 6JE

Our ref: KET/GAH/3015

Private and Confidential

Mr Mike Woodford
Hampshire Constabulary
Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire SO22 5DB

4 May 2001

Dear Mr Woodford

General Medical Council - Dr Jane Barton

As you are aware, this firm is instructed by the General Medical Council, the regulatory body of the medical profession.

It was a pleasure to meet you and your police colleagues on Wednesday.

I write to formally request disclosure of the following material which I understand is in the possession of acting DS Burt:

1. Statements made by the daughters of Gladys Richards deceased;

2. Statement of Dr Jane Barton;

3. Medical records of Gladys Richards deceased;

The above information will be placed before the Interim Orders Committee of the General Medical Council as soon as possible so that they may decide whether to take any action to limit Dr Barton's registration with the General

Medical Council, in the interest of protecting the public and pending the outcome of the police enquiries. As I explained to DS Burt, all documents passed to us will be disclosed to Dr Barton. It would also greatly assist the Interim Orders Committee if DS Burt or one of his colleagues would be able to provide information, probably in the form of a letter, explaining that there is an investigating currently proceeding and that a file has been submitted to the CPS. The letter should indicate, if possible, the nature of the charge that may be brought against Dr Barton and when the CPS might be expected to make a decision as to whether the case will proceed.

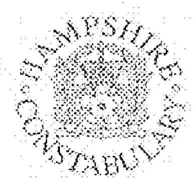
I understand that the police have an expert report from Brian Livesley. However, I further understand that this has not yet been disclosed to Dr Barton and that disclosure to us at the present time may prejudice the police investigation. I therefore do not request disclosure of this expert report.

As you will appreciate, the GMC will wish to act promptly to bring this mater before the Interim Orders Committee in the interest of protecting the public and I would be very grateful to hear from you as a matter of urgency with the requested documentation. You have indicated that you are prepared to release the documents to us for which I am extremely grateful.

Yours sincerely

Code A

Solicitors to the General Medical Council



HAMPSHIRE Constabulary

M N WOODFORD MBE TD DMA FCIS
Force Solicitor

West Hill, Winchester
Hampshire. SO22 5DB

Telephone: 0845 045 45 45
Ext: 79-1357/1356
Facsimile: 01962 871226
DX: 132262 Winchester 7

Your Ref:

Our Ref: D4/MNW/SB/misc.57/01

21 May 2001

Ms J Smith
General Medical Council
178 Great Portland Street
London
W1N 6JE

copy: DCI R Burt
Headquarters CID

Operation Rochester
Fratton Police Station

Dear Ms Smith

GENERAL MEDICAL COUNCIL – DR JANE BARTON

I refer to your fax of 15 May enclosing a copy of a letter dated 4 May 2001 addressed to me. I can confirm that I had not seen the 4 May letter from Kathy Tormann and that is the reason why a reply was not forthcoming.

We did meet in the Detective Chief Superintendent's office of this Headquarters and I would wish to stress that the Hampshire Constabulary will do all they can to assist the General Medical Council in reaching what will inevitably be a difficult decision. We are mindful of the Woolgar decision and have no difficulty releasing information to the GMC as a regulatory body concerned with health and safety.

However, we are keen to focus our attention on investigating any allegations of a criminal nature and we appreciate your understanding about the inappropriateness of perhaps disclosing something to the GMC which has not been made available to Dr Barton. There are clearly priorities when it comes to disclosure and it is better that information obtained by the police goes direct to Dr Barton rather than via the GMC.

With this in mind, we are going to release immediately the statements of the daughters of the late Gladys Richards, the statement of Dr Barton and the medical records of the late Gladys Richards. Those will be sent to you from Fratton Police Station where the officers dealing with Operation Rochester are based. We fully appreciate that, if you are to use the information supplied, it must be disclosed to Dr Barton. I can confirm that the documents you will receive are already in the doctor's possession having been disclosed to her by us.

I hope this deals with the various points you raise and, if we can be of any further assistance, please do not hesitate to contact us.

Yours sincerely

Code A

pp M N Woodford
Force Solicitor

Your reference D4/MNW/SB/misc.57/01
In reply please quote 2000/2047
Fax 0207 915 3642

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

22 May 2001

Private and Confidential

M N Woodford
Force Solicitor
Hampshire Constabulary
West Hill
Winchester
Hampshire
SO22 5DB

Dear M N Woodford

Thank you for your letter of 21 May 2001. We look forward to hearing from Fratton Police Station .

Yours sincerely

Code A

Mrs Hegarty
Fitness to Practise
Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

FITNESS TO PRACTISE DIRECTORATE

CONDUCT & REFERRALS

TELEPHONE MESSAGES

Call taken by: Seaton Giles	
Date: 25/5/01	Time: 17:25
Name of caller: DCI Ray Burt	Caller's status: DCI @ Hants Constabulary
'Phone number of caller: Code A	Address of caller: See File (if necessary)
Doctor(s) complained/enquired about Dr Barton	If we have file already open - file reference:

Summary of 'phone call:

1. DCI Burt called to inform us that the point of contact for this case is now the Force solicitor, Mike Woodford. Additionally, the senior investigating officer is now DSupt. John James, based at the same office as DI Sackman.
2. DCI Burt said that the police are anxious to assist re: the policy agreed in respect of the case of Dr Barton.
3. He will be writing to us regarding these matters.
4. However, he is more than willing to discuss this case on Tuesday 29 May if need be and may well phone you himself.

For next action by: Tuesday 29 May 2001

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Criminal Investigation Department
Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Our Ref. : HQ/CID/DCI 7410/2001

Your Ref. :

Code A

29th May 2001

Ms J. SMITH
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

Dear Jackie,

Re: Gladys Mable RICHARDS

I am writing to advise you that with effect from Monday 21st May 2001 the Senior Investigating Officer (SIO), in charge of the police enquiry into the circumstances of the death of Gladys Mable Richards at the War Memorial Hospital (Gosport) on the 21st August 1998 and any other alleged criminal matters that may stem from this investigation, became Detective Superintendent John James.

Detective Superintendent James is based at the Major Incident Complex, Police Station, Kingston Crescent, Portsmouth, Hampshire PO2 8BU (telephone no. 0845 045 4545 ext. 684-214).

Mike Woodford, the Force Solicitor, will continue to be your point of contact so far as disclosure of information in connection with your internal processes is concerned

Thank you for the assistance given to me during my tenure as SIO.

Yours Sincerely

Code A

Ray Burt
Detective Chief Inspector

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fratton Police Station
Kingston Crescent
Portsmouth
North End
Portsmouth
PO2 8BU

Our Ref. : Op Rochester

Your Ref. :

Tel. : 0845 045 45 45

Code A

06 June 2001

Ms J Smith
General Medical Council
178 Great Portland Street
London
W1N 6JE

Dear Ms Smith

GENERAL MEDICAL COUNCIL – DR JANE BARTON

I have been asked by DCI Ray BURT to provide you with the following documentation all previously disclosed to Dr BARTON.

1. Statement of Lesley LACK
2. Statement of Gillian MACKENZIE
3. Medical notes Gladys RICHARDS

Please accept my apologies for not supplying them earlier I have been on leave.

Yours Sincerely

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

?-JUN-2001 10:54 01705891562 INCIDENT ROOM RF 01705891562 P.01

Major Crime Complex
Kingston Crescent Police Station
North End
Portsmouth
Hampshire
PO2 8BU

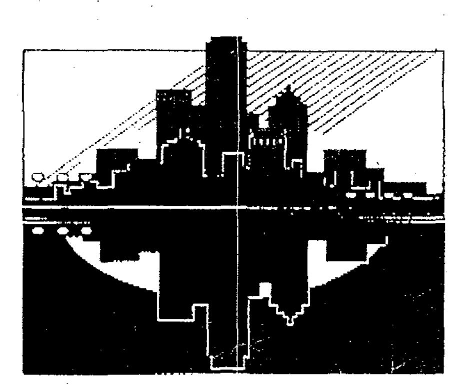
TO	Jackie SMITH	FROM	Code A
OF	GMC	TEL	
TEL		FAX	~~02073443753~~ 915 3642
DATE	12th June 01	OR	
Pages (inc)	12	Acknowledgement required please	
TEL	684 105	FAX	684 308

Location Code *(For Internal use only)* plus Extension Numbers

Jackie.

As promised – Dr BARTONS prepared statement

Dave S



Your reference

In reply please quote **JS/2000/2047**

Please address your reply to Fitness to Practise Directorate
Fax 020 7915 3696

13 June 2001

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Personal
Special Delivery: First Class

Dr (Mrs) J A Barton

Code A

Dear Dr Barton

I am writing to notify you that a person referred to in rule 4(1) ("the medical screener") of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1998[a] has considered information received by the GMC about your conduct.

Copies of the information received are attached, as listed in the index to the bundle.

The member, 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 in order that it may consider whether it is necessary for the protection of the 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(1) of the Medical Act 1983 as amended.

The screener has reached this decision after considering that the information received from Hampshire Constabulary is of such a nature that it may be both in the public interest and in your own interest that your registration to be restricted whilst those matters are resolved.

You are invited to appear before the Committee at 15:00 on Thursday 21 June 2001 at the Council's offices at 44 Hallam Street, London, W1, 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 Committee is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

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 Richard Clifford, Committee Section (fax no 020 7915 3696).

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 Interim Orders Committee 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 Richard Clifford, Committee Section (fax number as above), as soon as possible.

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

I enclose copies of the relevant provisions of the Medical Act, the Interim Orders Committee Procedure Rules, a paper about our fitness to practice procedures and a paper about the procedures of the Interim Orders Committee.

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.

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 all of your current employers including the Health Authority/Trust with which you have a service agreement, any locum 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 will you write personally to acknowledge receipt of this letter quoting the reference above.

Yours sincerely

Code A

Gerry Leighton
Assistant Registrar

Please quote our reference when communicating with us about this matter

Our ref : ISPB/EG-SC/9900079.Legal
Your ref : FPD/2000/2047
14 June 2001

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

Website www.the-mdu.com

PRIVATE AND CONFIDENTIAL
Ms Jackie Smith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE

BY POST AND BY FAX TO FAX NUMBER: 0207 915 3642

Dear Ms Smith

Re: Dr Jane Anne Barton – Interim Orders Committee 21 June 2001

Thank you for your letter of today's date by hand with the various papers concerning Dr Barton. Can I also thank you for taking the time trouble to liaise with me yesterday to let me know of the fact that the Screener had determined that Dr Barton's case should be referred to the Interim Orders Committee.

Having had an opportunity to consider the material it appears that the matter did not progress from 20 September 2000 when Detective Chief Inspector Burt wrote to the Fitness to Practise Directorate until some time the following year. As you will appreciate, the next documentation made available to me now is the letter from Detective Sergeant Sackman of 6 June 2001. I would be grateful if you could arrange for me to be provided with an explanation for that very significant interval of time, indicating precisely what steps were undertaken to investigate the matter if any.

As you will appreciate, Dr Barton is entitled to be made aware of the documentation which was considered by the Screener in reaching his/her decision to refer this matter to the Interim Orders Committee. I would be grateful if you could let me know precisely what documentation was considered by the Screener, and in the event that documentation was considered beyond the material made available to me now, if you could provide me with that documentation immediately.

Further, Dr Barton is entitled to receive written reasons for the decision of the Screener to refer this matter and I would be grateful once again if written reasons could be supplied immediately, bearing in mind the proximity of the Hearing.

Specialists in: Medical Defence Dental Defence Nursing Defence Risk Management

MDU Services Ltd is an agent for The Medical Defence Union Ltd (the MDU) and for Zurich Insurance Company, which is a member of the Association of British Insurers (ABI). The MDU is not an insurance company. The benefits of membership of the MDU are all discretionary and are subject to the Memorandum and Articles of Association.

Registered in England 3957086 Registered Office: 230 Blackfriars Road London SE1 8PJ (9900079)

I look forward to hearing from you as soon as possible.

Yours sincerely

Ian S P Barker
Solicitor

In reply please quote **FPD/2000/2047**

14 June 2001

Courier: Private & Confidential

Mr Ian Barker
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Barker

Dr Jane Ann BARTON (GMC Registration Number: 1587920)

Further to our telephone conversation yesterday, please find enclosed a copy of the papers relating to the above named doctor.

If you require any further information, please contact me.

Yours sincerely

Code A

Jackie Smith
Fitness to Practise

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Gerry Leighton
Assistant Registrar
General Medical Council
178, Great Portland Street
London W1W 5JE

Dr Jane Barton

Code A

Reference JS/2000/2047

14th June 2001

Dear Gerry,

I am writing to acknowledge receipt of your letter, reference above.

I intend to attend the meeting on Thursday 21st June 2001, accompanied by my barrister.

I am a self employed General Practtitioner with the Isle of Wight, Portsmouth and South East Hants Health Authority.

I am also currently employed as the Chair of the Gosport Primary Care Group, a sub committee of the above Health authority.

Yours Sincerely

Code A

Dr Jane Barton

Your reference

In reply please quote **JS/2000/2047**

Please address your reply to Fitness to Practise Directorate
Fax 020 7915 3642

19 June 2001

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Confidential: By Fax

Mr I S P Barker
Solicitor
MDU Services Limited
230 Blackfriars Road
London SE1 8PJ

Dear Mr Barker

Dr Jane A BARTON

I am writing further to your faxed letter dated 14 June 2001.

In relation to the first point in your letter, after we received the letter dated 20 September 2000 from the police we made contact with them requesting further information. They supplied to us, on 6 June 2001, the documentation which was served on Dr Barton with the Notice of Referral to the IOC dated 13 June 2001.

The Screener, in reaching his decision, considered the documentation which was supplied to us by the police on 6 June 2001 and which was served on Dr Barton on 13 June 2001.

The Screener decided to refer this matter to the IOC because he felt that the information from Hampshire Constabulary is of such a nature that it may be both in the public interest and in Dr Barton's own interest that her registration be restricted whilst matters are resolved.

Yours sincerely

Code A

Jackie Smith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Please quote our reference when communicating with us about this matter

Our ref : ISPB/EG-GP/9900079.Legal
Your ref :
19 June 2001

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

Website www.the-mdu.com

PRIVATE AND CONFIDENTIAL
Ms Jackie Smith
Fitness To Practise Directorate
The General Medical Council
178 Great Portland Street
London
W1W 5JE

BY POST AND BY FAX TO FAX NUMBER: 020 7915 3642

Dear Ms Smith

Re: Dr Jane Barton – Interim Orders Committee, 21 June 2001

Thank you for your letter of today's date by fax, and I am grateful for the information you have provided.

I would be grateful if you could help me with some further clarification in relation to the second paragraph of your letter. It would appear that, having received the letter dated 20 September 2000, the General Medical Council then requested information from the police, presumably shortly after that date. I would be grateful if you could confirm that that indeed is the case.

It would seem then that the police failed to respond until 6 June 2001. Again, I would be grateful if you could confirm if that is indeed the case, and if not, let me know of the intervening correspondence or communication.

I look forward to hearing from you as soon as possible.

Yours sincerely

Code A

Ian S P Barker
Solicitor

Specialists in: Medical Defence Dental Defence Nursing Defence Risk Management

MDU Services Ltd is an agent for The Medical Defence Union Ltd (the MDU) and for Zurich Insurance Company, which is a member of the Association of British Insurers (ABI). The MDU is not an insurance company. The benefits of membership of the MDU are all discretionary and are subject to the Memorandum and Articles of Association.

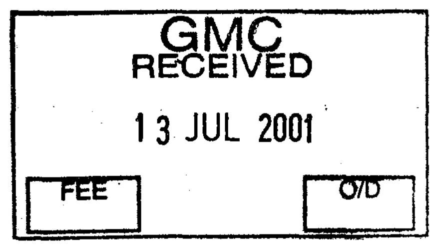
Registered in England 3957086 Registered Office: 230 Blackfriars Road London SE1 8PJ (GMC3.DOC)

Richard Gifford

12 July 2001

NAT14181604/23

Direct line: Code A



Customer Service Centre
Slindon Street
PORTSMOUTH
PO1 1AA

Tel: 0845 7740 740
Website www.royalmail.com

Text Phone 0845 600 0606
(for the deaf and hard of hearing)

Mr R Beard
GMC
178-202 Great Portland Street
LONDON
W1W 5JE

Dear Mr Beard

Thank you for your enquiry of 10 July regarding a Special Delivery letter number SJ0581 9662 9GB which you sent to Doctor J A Barton, 11 Village Road, Gosport, PO12 2LD.

I am pleased to enclose a copy of the receipting signature that was obtained when the letter was delivered on 28 June 2001.

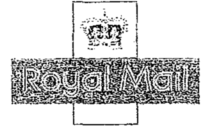
Yours sincerely

Code A

Lynne Dugan
Customer Service Advisor

To ensure that we maintain the highest possible standards, the service we provide to you is monitored on our behalf by a research agency. Each month telephone interviews are conducted with a sample of the customers with whom we have been in contact. If you would prefer not to be contacted please call Freephone 0800 652 5900 within 7 days of the date of this letter and quote the reference above.

Royal Mail is a trading name of Consignia plc. Registered number 4138203.
Registered in England and Wales. Registered office: 148 Old Street, LONDON, EC1V 9HQ.



CONFIRMING YOUR DELIVERY

28/6/01
Date stamp

Affix the item barcode number and enter the time of delivery, or attempted delivery. The recipient must sign and print their name before the item is handed over.

Confirmed on track/trace *PHG initials* 3

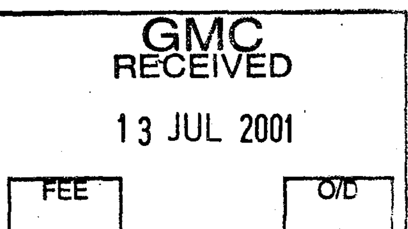
Walk		Number of items for delivery		Number of items undelivered	
ID	Name	Priority	Recorded	Returned	Pouched off
0102C	CALLGRS				

	Barcode here	Time	
RA	7961 7552 4GB		1
SJ	0581 9662 9GB	1150	2
SJ	0736 3436 1GB	1155	3
SJ	0736 3434 4GB	1155	4

(*)

Code A

Retain for one year P4550 Revised October 98 PRI 498024



Your reference

In reply please quote Code A

Please address your reply to Fitness to Practise Directorate
Fax 020 7915 3642

22 June 2001

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Confidential: By Fax

Mr I S P Barker
Solicitor
MDU Services Limited
230 Blackfriars Road
London SE1 8PJ

Dear Mr Barker

Dr Jane A BARTON

Please accept my apologies for misleading you, Dr Barton and your Counsel about the documentation the Screener saw when he decided to refer Dr Barton's case to the IOC.

I overlooked the fact the Dr Barton's prepared statement to the police had come in separately on the fax machine on 12 June 2001. This was seen by the Screener, along with the other material which came in on 6 June 2001, when he considered the case on 12 June 2001. As previously stated the Screener saw that which was served on Dr Barton on 13 June 2001.

I apologise for any distress and inconvenience caused to Dr Barton and would like to assure that I did not deliberately intend to mislead you, Dr Barton or the Committee.

Yours sincerely

Code A

Jackie Smith
Fitness to Practise Directorate

Code A

cc: Dr Barton

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

E:\C\IOC\FOLLOWUP\BARTON

Your reference

In reply please quote **RC/HW/2000/2047**

Please address your reply to the Committee Section FPD
Fax 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

25 June 2001

Special Delivery: Personal

Dr J A Barton

Code A

Dear Dr Barton

I am writing to confirm that, at the conclusion of the proceedings before the Interim Orders Committee on 21 June 2001 the Chairman announced the Committee's determination as follows:

> "Dr Barton : The Committee has carefully considered all the evidence before it today.
>
> The Committee has determined that it is 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 41A of the Medical Act 1983 should be made in relation to your registration."

Yours sincerely

Code A

Richard Clifford
Assistant Registrar

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

In reply please quote NV\21JuneIOC

Please address your reply to the Committee Section FPD
Fax 020 7915 3696

25 June 2001

By fax (0113 254 5793) and
First Class: Confidential

Barbara Carter
NHS Executive
Room 2W10
Quarry House
Leeds LS2 7UE

Dear Mrs Carter

I am writing to confirm the decisions taken by the GMC's Interim Orders Committee at its meeting on 21 June 2001. The decisions were as follows:

Name: NAGMOTI, Vidyashankar Gangadhar

Registration number: Code A

Registered address: **Code A**

Qualifications: MB BS 1973 Bangalore

Decision: Order for the following interim conditions for a period of 18 months made on 20 September 2000 was reviewed, and an Order directing that it should remain place was made.

1. Except in life-threatening emergencies, you shall undertake all examinations of an intimate nature upon female patients in the immediate presence of another GMC registered medical practitioner or a practitioner registered with the United Kingdom Central Council of Nursing, Midwifery and Health Visiting. In the event of a patient rejecting the presence of the qualified chaperone during the examination, you should not proceed unless an appropriate consent is signed by the patient.

2. Your records of all such examinations must include the name and signature of the chaperone.

3. You shall comply with the monitoring of the chaperone arrangements as set out by the Health Authority.

4. You shall continue to display the amended practice notice on

chaperone arrangements to reflect these conditions.

Name: VERMA, Surendra Pratap Singh

Registration number: Code A

Registered address: Code A
Code A

Qualifications: MB BS 1964 Vikram

Decision: No order made

Name: SAVANI, Arjun Damjibhai

Registration number: Code A

Registered addres Code A

Qualifications: MB BS 1993 Saurashtra

Decision: Order for the following Interim Conditions made, with effect from 21 June 2001.

1. You shall undertake all consultations with female patients in the immediate presence of another GMC registered medical practitioner or a practitioner registered with the United Kingdom Central Council of Nursing, Midwifery and Health Visiting. In the event of a patient rejecting the presence of the qualified chaperone during the examination, you should not proceed with the consultation;

2. You shall notify all current and potential employers at the time of application, whether for voluntary or paid work which requires registration with this Council, of the conditions imposed on your registration by this Committee;

3. You shall notify the Registrar of the GMC of any such posts you undertake.

Name: CHRISTIAN, Moses E P

Registration number: 4564971

Registered address: Health Centre Llanfair Caereinion Welshpool Powys SY21 0RT

Qualifications: MB BS 1989 Madras

Decision: Order for the Interim Suspension for a period of 18 months with effect from 21 June 2001

Name: BARTON, Jane Ann

Registration number: Code A

Registered address: Code A

Code A

Qualifications: MB BCh 1972 Oxford

Decision: No order made

In new cases, the orders will be subject to review within six months of coming into force, and review cases will be subject to further review within three months.

Yours sincerely

Nilla Varsani
Committee Section

Code A

cc. Angela Hawley, NHS Executive

SUNDAY TELEGRAPH
29/07/01

Police investigate nine deaths at cottage hospital

BY DAVID BAMBER 2
Home Affairs Correspondent

DETECTIVES ARE investigating the deaths of nine patients at a cottage hospital following complaints from relatives, *The Sunday Telegraph* has learnt.

The inquiry into the fatalities, at the Gosport War Memorial Hospital, near Portsmouth, was prompted by concerns about the death of an elderly woman who was prescribed diamorphine, the pain-killing drug.

Other families contacted Hampshire Police after the initial complaint. The fatalities are said to have all taken place over three years.

A spokesman for Hampshire Police last night confirmed that investigations were continuing. One complaint has already been investigated and a file sent to the Crown Prosecution Service.

The spokesman said: "We have been contacted by the relatives of nine people who were concerned about deaths of their relatives at the hospital. The situation now is that we are speaking to four of those people about what their concerns are and are making preliminary inquiries."

Ian Piper, the operational director of Portsmouth HealthCare NHS Trust which runs the hospital, confirmed that the authority was helping police with their investigations.

He said: "I am aware that the police are undertaking preliminary inquiries into a number of cases. Eight people have come forward in addition to the original complainant.

"The trust will assist the police with their preliminary inquiries. We have every confidence in the staff at the hospital and the care they provide."

Gillian Mackenzie, whose 91-year-old mother died at the hospital after being prescribed diamorphine, contacted police in 1998. A file on the case has been sent by Hampshire CID to the Crown Prosecution Service.

Solicitors at the CPS have so far recommended that there is insufficient evidence for charges of unlawful killing to be brought, although the case has not been closed by the police.

Mrs Mackenzie, 63, of Eastbourne, East Sussex, said: "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."

She added: "I am glad the police are investigating these cases at the hospital. They are all similar to my mother's and we must get to the bottom of what was happening."

Jackie

File note of telephone conversation.

I spoke with CPS lawyer Paul Close who told me that the CPS had decided not to pursue any matters with Dr Barton and she would not be charged with any offences in respect of the death of Gladys Richards.

Code A

Jackie Smith
7 August 2001.

File note of telephone conversation.

Det Supt James rang to say that the police are going to investigate the other 9/10 suspicious deaths at the Gosport War Memorial, and they will be seeking an expert opinion but will not be using Professor Livesley again.

Det Supt said that he would confirm the above in writing but hopes to be in a position to let all parties know what is happening by the end of September 2001.

Code A

Jackie Smith
13 August 2001.

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM

Your Ref. : 2000/2047 -MH

Tel. : 0845 045 45 45
Direct Dial :
Fax. : 023 9289 1504

14 August 2001

Ms J Smith
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 7JJ

Dear Ms Smith

Re: Dr Jane BARTON

I am writing to notify you that on Friday 10th August 2001, I received written confirmation from the Crown Prosecution Service informing me of Senior Treasury Counsel's advice regarding the matters about which Dr BARTON was interviewed by the Police.

The advice is that, based on the papers submitted to the Crown Prosecution Service by Hampshire Constabulary, there is insufficient evidence to support a viable prosecution against Dr BARTON with regard to the death of Mrs Gladys RICHARDS.

As Senior Investigating Officer for the enquiry I have accepted this advice.

In the absence of any other significant evidence being forthcoming no further action will be taken against Dr BARTON in relation to the death of Mrs Gladys RICHARDS.

I must advise you that following publicity concerning the enquiry into Mrs RICHARDS death a number of members of the public have contacted the enquiry team expressing concerns about the circumstances attendant to the deaths of relatives who had died at the Gosport War Memorial Hospital. I must further advise you that we are conducting preliminary enquiries to determine whether or not these other matters should be the subject of a more intensive police investigation.

HAMPSHIRE Constabulary

I anticipate that these enquiries will be completed within the next six to eight weeks. I will advise you at the earliest opportunity of the outcome of our investigation.

Yours sincerely

Code A

J JAMES
Detective Superintendent

Your reference Code A

In reply please quote Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

17 August 2001

J James
Detective Superintendent
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
Portsmouth PO2 8BU

Dear Detective Superintendent James

Thank you for your letter of 14 August 2001, the contents of which have been noted. We shall await your further correspondence and in particular the outcome of the further investigations.

Yours sincerely

Code A

Ms W Bannister
Fitness to Practise

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

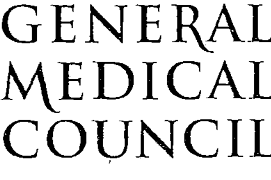
Your reference: MIC/Det.Supt/JJ/DM

In reply please quote: 2000/2047

7 February 2002

First Class Post

Det Supt James
Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU



Dear Det Supt James

Dr Jane Barton

I write further to your previous correspondence with my colleague Jackie Smith regarding the above case. Ms Smith has now moved to a new role within the GMC and responsibility for this case has passed to me. I tried contacting you by telephone today but was informed that you were out of the office.

I have today been informed that your investigation is now complete and that it has recently been that no criminal charges should be brought against Dr Barton. I should be grateful if you would confirm in writing, at your earliest possible convenience, that this is indeed the case.

As the statutory body responsible for regulating the medical profession, we are obviously concerned to learn of any doctor who is, or who has been, the subject of a criminal investigation. Whilst acknowledging the decision not to prosecute Dr Barton, before closing our file we must nevertheless satisfy ourselves that that there are no matters relating to her professional conduct or performance which may warrant formal action under the Council's fitness to practise procedures. I understand that you may be in possession of expert witness reports which are critical of the practices of both Dr Barton and a Dr Althea Lord.

In order to assist us in this regard I should be grateful if you would arrange for the following documentation to be forwarded to this office:

1. A brief case summary

2. Copies of witness statements

3. Copies of expert reports

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

4. Copies of relevant medical records, if available

We appreciate that when disclosing confidential information you need to balance the rights of privacy of the individual against a necessary need to protect the public.

For your information I am enclosing under cover of this letter a copy of the Medical Act 1983 (Amendment) Order 2000. In particular I would draw your attention to Section 35A of the Amendment Order which, in broad terms, gives the GMC the right to demand disclosure of information in certain circumstances where it is considered necessary for the purpose of assisting us to carry out our statutory regulatory role. I trust that on reviewing the legislation you will agree that, given both the nature of the original concerns about Dr Barton's practice and her public position, our request for information is be both reasonable and relevant.

It may also be helpful in this respect if I draw your attention to the comments of *Kennedy LJ* in the case *of Woolgar v Chief Constable of Sussex Police (2000) 1 WLR 25* where he stated:

> *Obviously in each case a balance has to be struck between competing public interests and at least arguably in some cases the reasonableness of the Police view may be opened to challenge. If they refuse to disclose, the regulatory body may, if aware of the existence of the information, make an appropriate Application to the Court."*

Should you have any further questions please do not hesitate to contact me. Thank you for your assistance in this matter. I look forward to hearing from you at your earliest possible convenience.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM
Your Ref. : 2000/2047

Tel. : 0845 045 45 45
Direct Dial :
Fax. : 02392 891884

14 February 2002

Mr M Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Mr Hudspith

Re: Dr Jane BARTON

I am writing following your letter of the 7th February and our conversation of the 13th concerning the above named.

As I outlined to you the enquiry at Gosport War Memorial Hospital has generated a significant amount of documentation.

In the first instance, as agreed, I will arrange for you to be copied:

- Any statements/reports referred to in the LIVESLEY, FORD, MUNDY reports.
- Patient notes for any person referred to in the above reports.
- Any other obvious supporting documentation.

I will arrange for Code A to collate the papers. If you have any queries he can be contacted on Code A

CRIMESTOPPERS 0800 555 111

HAMPSHIRE Constabulary

Should you, after receiving the first tranche of documents, identify further material you would like disclosed please contact David direct.

If I can be of any other assistance please advise.

Yours sincerely

Code A

J JAMES
Detective Superintendent

GMC100829-0130

Portsmouth HealthCare
NHS Trust

Department of Medicine for Elderly People
South Block
Queen Alexandra Hospital
Cosham
Portsmouth
PO6 3LY

Tel 023 9220 6000
Fax 023 9220 0381

FAX
Please telephone if any page is missing or indistinct.

TO: GENERAL MEDICAL COUNCIL

DATE: 21/02/02

FOR THE ATTENTION OF: MICHAEL HUDSPITH

FAX NO: 0207 915 3642

FROM: Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
PORTSMOUTH
PO6 3LY

NO. OF PAGES INCLUDING THIS SHEET: 2

TEL: Code A

CONFIDENTIAL

This fax may contain confidential information and you may not be the intended recipient, you must not copy or make any unauthorised disclosure of such information. If you have received this fax in error, please destroy the original and telephone 023 9228 6919 or 023 9228 6920 immediately.

MESSAGE:

I have been unable to contact Dr. Old so far today re his letter to Dr. Barton but will be in contact in due course about this.

Regards

Dr. Ian Reid

Portsmouth HealthCare NHS
NHS Trust

Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
Portsmouth
Hants
PO6 3LY

Tel 023 9228 6000
Fax 023 9220 0381

PRIVATE AND CONFIDENTIAL
Dr J A Barton
The Surgery
148 Forton Road
Gosport
Hants PO12 3HH

13 February 2002

RIR/cmp

Dear Dr ~~Barton~~ Jane

Following our meeting I am writing to confirm what we agreed.

We agreed that you would cease to provide in patient care, both in and out of hours, for patients on Sultan Ward at Gosport War Memorial Hospital.

We agreed that you would continue to use Healthcall to cover your on call commitments in respect of your Practice's contract to provide out of hours cover to Daedalus and Dryad Wards.

We agreed that we would review this arrangement after there was clarity about your referral (or otherwise) to the Interim Orders Committee of the General Medical Council, or in one months time, which ever is sooner.

We also agreed to conduct a retrospective audit of your prescribing on Sultan Ward.

Thank you very much for your co-operation in this matter.

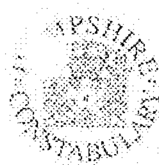
Yours sincerely

Code A

Dr R I Reid
Medical Director

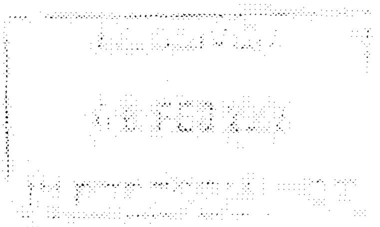
cc: Dr Peter Old

GMC100829-0132



HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable



Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref : MIC/Det Supt/JJ/DM
Your Ref :

Tel : 0845 045 45 45
Direct Dial :
Fax : 023 9289 1884

06 February 2002

Ms J Smith
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Ms Smith

Re: Dr Jane BARTON and Dr Anthea Everista Geredith LORD

I am writing following my letter to you of the 14th august 2001, concerning police investigations into patient deaths at Gosport War Memorial Hospital. You will note that this correspondence referred to preliminary police investigations to determine whether or not an intensive investigation of deaths at Gosport War Memorial Hospital was warranted.

In furtherance of those investigations expert reports were commissioned in respect of four other patient deaths and a further review of a particular death, Gladys RICHARDS in August 1998, which was previously subject of correspondence with the GMC. Receipt of the further reports was delayed for a number of reasons beyond our control.

However, they have now been reviewed and it has been determined that at this stage no further police investigations are appropriate. This decision is subject to review should further substantial evidence become available.

In reviewing the reports (which are enclosed) it is clear that the commentary and conclusions of the authors raise very serious concerns about the standard of clinical and nursing care delivered to the named patients at Gosport War Memorial Hospital. Specifically the care delivered by Dr BARTON is subject to particular criticism and raises concerns about her professional conduct. To a lesser extent there are implicit concerns about the professional conduct of Dr LORD as the consultant physician who had overall responsibility for patients on Daedulus and Dryad wards at Gosport War Memorial Hospital.

HAMPSHIRE Constabulary

It is my conclusion that the reports should be disclosed to you as the regulatory body for the named individuals for your action as appropriate. I should further advise that disclosure to you is for the purpose as described on the advice of our Force solicitor and disclosure to any third party should be referred back to us in the first instance.

If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Code A

J JAMES
Detective Superintendent

c.c. Julie MILLER
Investigations Manager
Commission for Health Improvement

CRIMESTOPPERS 0800 555 111

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

MEDICO-LEGAL REPORT

Re: **Gladys Mabel RICHARDS**
Arthur "Brian" CUNNINGHAM
Alice WILKE
Robert WILSON
Eva PAGE

Prepared by:
Professor G A Ford, MA, FRCP
Consultant Physician, Freeman Hospital
Newcastle upon Tyne
Professor of Pharmacology of Old Age, University of Newcastle upon Tyne

For: **Hampshire Constabulary**

Date: **12th December 2001**

Contents

8 Introduction and remit of the report
9 Report on Gladys Mabel Richards
10 Report on Arthur "Brian" Cunningham
11 Report on Alice Wilkie
12 Report on Robert Wilson
13 Report on Eva Page
14 Opinion on clinical management at Gosport War Memorial Hospital
15 Appendix 1 – Pharmacology of opiate and sedative drugs
16 Appendix 2 – British National Formulary guidelines on prescribing in palliative care and prescribing in the elderly

Introduction and Remit of the Report

8.1 I am Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology at the University of Newcastle upon Tyne, and a Consultant Physician in Clinical Pharmacology at Freeman Hospital. I am a Doctor of Medicine and care for patients with acute medical problems, acute poisoning and stroke. I have trained and am accredited on the Specialist Register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I provide medical advice and support to the Regional Drugs and Therapeutics Centre Regional National Poisons Information Service. I was previously clinical head of the Freeman Hospital Care of the Elderly Service and have headed the Freeman Hospital Stroke Service since 1993. I undertake research into the effects of drugs in older people. I am co-editor of the book 'Drugs and the Older Population' and in 2000 was awarded the William B Abrams award for outstanding contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a Fellow of the Royal College of Physicians and have practised as a Consultant Physician for nine years.

8.2 I have been asked by Detective Superintendent John James of Hampshire Constabulary to examine the clinical notes of five patients (Gladys Mabel Richards, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson, Eva Page) treated at the Gosport War Memorial Hospital and to apply my professional judgement to the following:

- The gamut of patient management and clinical practices exercised at the hospital
- Articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved
- The accuracy of diagnosis and prognosis including risk assessments
- An evaluation of drugs prescribed and the administration regimes
- The quality and sufficiency of the medical records
- The appropriateness and justification of the decisions that were made
- Comment on the recorded causes of death
- Articulate the duty of care issues and highlight any failures

1.3 I have prepared individual reports on each case and an additional report commenting on general aspects of care at Gosport War Hospital from a consideration of all five cases.

1.4 I have been provided with the following documents by Hampshire Constabulary, which I have reviewed in preparing this report:

- Comment on the recorded causes of death
- Letter DS J James dated 15th August 2001
- Terms of Reference document
- Hospital Medical Records of Gladys Richards, Brian Cunningham, Alice Wilkie, Robert Wilson and Eva Page
- Witness statements by Leslie France Lack, and Gillian MacKenzie
- Report of Professor Brian Livesley
- Transcripts of police interviews with Gosport War Memorial staff Dr Barton, Mr Beed, Ms Couchman, Ms Joice

- Transcript of police interviews with Royal Hospital Haslar staff Dr Reid and Flt. Lt. Edmondson
- Transcript of interviews with patient transfer staff Mr Warren and Mr Tanner
- Transcript of police interviews with or statements from following medical and nursing staff: Dr Lord, LM Baldacchino, M Berry, JM Brewer, J Cook, E Dalton, W Edgar, A Fletcher, J Florio and A Funnell.

Gladys Mabel RICHARDS

Course of Events

2.1 Gladys Richards was 91 years old when admitted as an emergency via the Accident & Emergency Department to Haslar Hospital on 29[Th] July 1998. She had fallen onto her right hip and developed pain. At this time she lived in a nursing home and was diagnosed as having dementia. She had experienced a number of falls in the previous 6 months and the admission notes comments "*quality of life has ↓↓ markedly last 6/12*". She was found to have a fracture of the right neck of femur. An entry in the medical notes by Surgeon Commander Malcom Pott, Consultant orthopaedic surgeon dated 30 July 1998 states '*After discussion with the patient's daughters in the event of this patient having a cardiac arrest she is NOT for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished.*' Surgery (right hemiarthroplasty) was performed on 30 July 1998.

2.2 On 3rd August she was referred for a geriatric opinion and seen by Dr Reid, Consultant Physician in Geriatrics on 3rd August 1998. In his letter dated 5th August 1998 he notes she had been on treatment with haloperidol and trazadone and that her daughters thought she had been 'knocked off' by this medication for months, and had not spoken to then for 6-7 months. Her mobility had deteriorated. Her daughters commented to Dr Reid that she had spoken to them and had been brighter mentally since the trazadone had been omitted following admission. Dr Reid found Mrs Richards to be confused but pleasant and cooperative, unable to actively lift her right leg from the bed but appeared to have little discomfort on passive movement of the right hip. He commented '*I understand she has been sitting out in a chair and I think that despite her dementia, she should be afforded the opportunity to try to re-mobilise her.* He arranged for her transfer to Gosport War Memorial Hospital.

2.3 Following Dr Reid's entry in the notes on 3rd August two further entries are made in the medical notes by the on call house officer (Dr Coales?) on 8th August 1998. Dr Coales was asked to see Mrs Richards who was agitated on the ward. She had been given 2mg haloperidol and was asleep when first seen at 0045h. At 02130 hr a further entry records Mrs Richards was '*noisy and disturbing other patients n ward. Unable to reason with patient. Prescribed 25mg thioridazine'*. A transfer letter for Sergeant Curran, staff nurse to the Sister in Charge dated 10th August 1998 describes Mrs Richards status immediately prior to transfer and notes *'Is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes.*

2.4 On 11th August 1998 Mrs Richards was transferred to Daedalus ward. Dr Barton writes *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 summary admitting nursing notes record "*now fully weight bearing and walking with the aid of two nurses and a Zimmer frame*". On 12th August the nursing notes record "*Haloperidol given at 2330 as woke from sleep. Very agitated, shaking and crying. Didn't settle for more than a few*

minutes at a time. Did not seem to be in pain".On 13th August nursing notes record "*found on floor at 1330h. Checked for injury none apparent at time. Hoisted into safer chair. 1930 pain Rt hip internally rotated, Dr Brigg contacted advised Xray am and analgesia during the night. Inappropriate to transfer for Xray this pm."*

2.5 On 14th August 1998 Dr Barton wrote '*sedation/pain relief has been a problem. Screaming not controlled by haloperidol 1g ? but very sensitive to Oramorph. Fell out of chair last night. R hip shorter and internally rotated, Daughter nurse and not happy. Plan Xray.. Is this lady well enough for another surgical procedure?"* A further entry the same day states "*Dear Cdr Spalding, further to our telephone conversation thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her R hip. Hemiarthroplasty was done on 30-8-98. I am sending Xrays. She has had 2.5ml of 10mg/5ml oramoroph at midday. Many thanks*".

2.6 Following readmission to Haslar hospital Mrs Richards underwent manipulation of R hip under iv sedation (2 mg midazolam) at 1400h. At 2215h the same day she was not responding to verbal stimulation but observations of blood pressure, pulse, respiration and temperature were all in the normal range. A further entry on 17th August by Dr Hamlin (House Officer) states "*fit for discharge today (Gosport War Mem) To remain in straight knee splint for 4/52. For pillow between legs (abduction) at night.*" A transfer letter to the nurse in charge at Daedalus ward states "*Thank you for taking Mrs Richards back under your care... was decided to pass an indwelling catheter which still remains in situ. She has been given a canvas knee immobilising splint to discourage any further dislocation and this must stay in situ for 4 weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing*".

2.7 Nursing notes record on 17th August " 1148h *returned from R.N.Haslar patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew."* Later that day at 1305h "*in pain and distress, agreed with daughter to give her mother Oramorph 2.5mg in 5ml*". A further hip Xray was performed which demonstrated no fracture. Dr Barton writes on 17th August 1998 *"readmission to Daedalus ward. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again"* and on 18th August "*still in great pain, nursing a problem, I suggest sc diamorphine/ haloperidol/midazolam. I will see daughters today. Please make comfortable*". Nursing notes record "*reviewed by Dr Barton for pain control via syringe driver*". At 2000h "*patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs*". On 19th August the nursing notes record "*Mrs Richards comfortable*" and in a separate entry "*apparently pain free*". There are no nursing entries I can find on 20th August. I can find no entries in the nursing notes describing fluid or food intake following admission on 17th August.

2.8 The next entry in the medical notes is on 21st August by Dr Barton "*much more peaceful. Needs hyoscine for rattly chest*". The nursing notes record "*patient's overall condition deteriorating. Medication keeping her comfortable*". A staff

nurse records Mrs Richards's death in the notes at 2120h later that day. The cause of death was recorded as bronchopneumonia.

2.9 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards's first admission to Haslar Hospital.

29 July 2000h Trazadone 100mg (then discontinued)
29 July to 11th August. Haloperidol 1mg twice daily
30 July 0230h Morphine iv 2.5mg
31 July 0150h morphine iv 2.5mg
1905h morphine iv 2.5 mg
1 Aug 1920h morphine iv 2.5mg
2 Aug 0720h morphine iv 2.5mg
Cocodamol two tablets as required taken on 16 occasions at varying times between 1-9th August

2.10 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards second admission to Haslar Hospital

14 Aug 1410h midazolam 2mg iv
15 Aug 0325h cocodamol two tablets orally
16 Aug 0410h haloperidol 2mg orally
0800h haloperidol 1mg orally
1800h haloperidol 1mg orally
2310h haloperidol 2mg orally
!7 Aug 0800h haloperidol 1mg orally

2.11 Medication charts record the following administration of opiate and sedative drugs on Daedalus ward:

11 Aug	1115h	5mg/5ml Oramorph
	1145h	10 mg Oramorph
	1800h	1 mg haloperidol
12 Aug	0615h	10 mg Oramorph
		haloperidol
13 Aug	2050h	10mg Oramorph
14 Aug	1150h	10mg Oramorph
17 Aug	1300h	5mg Oramorph
	?	5 mg Oramorph
	1645h	5mg Oramorph
	2030h	10mg Oramorph
18 Aug	0230h	10mg Oramorph
	?	10mg Oramorph
	1145h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hrby
19 Aug	1120h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
20 Aug	1045h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
21 Aug	1155h	diamorphine 40mg/24h, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

2.12 Primary responsibility for the medical care of Mrs Richards during her two admissions to Gosport Hospital lay with Dr Lord, as the consultant responsible for his care. My understanding is that day-to-day medical care was delegated to the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital (statement of Dr Lord in interview with DC Colvin and DC McNally). Primary responsibility for the medical care of Mrs Richards during her two admissions to Queen Alexandra Hospital lay with Surgeon Commander Scott, Consultant Orthopaedic Surgeon. Junior medical staff were responsible for day-to-day medical care of Mrs Richards whilst at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Richards and informing medical staff of any significant deterioration.

2.13 Dr Reid, Consultant Geriatrician was responsible for assessing Mrs Richards and making recommendations concerning her future care following her orthopaedic surgery, and arranged transfer to Gosport Hospital for rehabilitation.

Accuracy of diagnosis and prognosis including risk assessments

2.14 The initial assessment by the orthopaedic team was in my opinion competent and the admitting medical team obtained a good history of her decline in the previous six months. Surgeon Commander Pott discussed management options with the family and a decision was made to proceed with surgery but for Mrs Richards to not undergo cardiopulmonary resuscitation if she sustained a cardiac arrest, with a clear decision to keep Mrs Richards pain free, hydrated and nourished. There are good reasons to offer surgery for a fractured neck of femur to very frail patients with dementia even when a high risk of peri-operative death or complications is present. This is because without surgery patients continue to be in pain, remain immobile and nearly invariably develop serious complications such as pneumonia and pressure sores, which are usually fatal. From the information I have seen I would, as a consultant physician/geriatrician recommended the initial management undertaken. I consider it good management that the trazadone as discontinued when the history from the daughters suggested this might have been responsible for decline in the recent past.

2.15 After Mrs Richards was stable a few days following surgery it was appropriate to refer her for a geriatric opinion, and Dr Reid rapidly provided this. Dr Reid's assessment was in my opinion thorough and competent. He identified the potential for her to benefit from rehabilitation. I would consider his decision to refer her for rehabilitation despite her dementia to be appropriate. An elderly care rehabilitation, rather than an acute orthopaedic ward is in general a preferable environment to undertake such rehabilitation. It is implicit in his decision to transfer her to Gosport War Memorial Hospital that she would receive rehabilitation there and not care on a continuing care ward without input from a rehabilitation team. Dr Lord in an interview with DC McNally and DC Colvin describes Daedalus ward as "*Back in '98 .. Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke*

rehabilitation". Although Mrs Richards had a fractured neck of femur and not stroke as her primary problem requiring rehabilitation I would assume, in the light of Dr Reid's letter that she was transferred to one of the 8 slow stream rehabilitation beds on Daedalus ward.

2.16 The transfer letter from Sergeant Curran provides a clear description of Mrs Richards's status at the time of transfer. The observation that she was walking with the aid of two nurses and a zimmer frame, and the usual cause of agitation was when she needed to use the toilet are relevant to subsequent events following transfer to Gosport Hospital. The use of a Barthel Index score as a measure of disability is good practice and demonstrates that Mrs Richards was severely dependent at the time of her transfer to Gosport Hospital.

2.17 The initial entry by Dr Barton following Mrs Richards' transfer to Daedalus ward does not mention that she has been transferred for rehabilitation, and focuses on keeping her 'comfortable' despite recording that she is "*not obviously in pain*". The statement '*I am happy for nursing staff to confirm death*" also suggests that Dr Barton's assessment was that Mrs Richards might die in the near future. Dr Barton in her statement to DS Sackman and DC Colvin, confirms this when she states "*I appreciated that there was a possibility that she might die sooner rather than later*". Dr Barton refers to her admission as a "*holding manoeuvre*" and her statement suggests a much more negative view of the potential for rehabilitation. She does not describe any rehabilitation team or focus on the ward and suggests her transfer was necessary because she was not appropriate for an acute bed, rather than her being appropriate for rehabilitation- "*.her condition was not appropriate for an acute bed. ....seen whether she would recover and mobilise after surgery. If as was more likely she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a clam environment away from the stresses of an acute ward*". In my opinion this initial note entry and the statement by Dr Baron indicate a much less proactive view of rehabilitation, less appreciation than Dr Reid of the potential for Mrs Richards to recover to her previous level of functioning, and probably a failure to appreciate the potential benefits of appropriate multidisciplinary rehabilitation to Mrs Richards. This leads me to believe that Dr Barton's approach to Mrs Richards was in the context of considering her as a continuing care patient who was likely to die on the ward. It was not wrong or incorrect of Dr Barton to believe Mrs Richards might die on the ward, but I would consider her apparent failure to recognise Mrs Barton's rehabilitation needs may have led to subsequent sub-optimal care.

2.18 There are a number of explanations and contributory factors that may have led to Dr Barton possibly not recognising Mrs Richard's rehabilitation needs in addition to her nursing and analgesic needs. First she may have not clearly understood Dr Reid's assessment that she needed rehabilitation. In her statement Dr Barton states " *Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to remobilise*" which suggests Dr Barton may not have considered the necessity for Mrs Richards to receive Physiotherapy as a necessary part of her opportunity to remobilise. Second the ward had both continuing care and rehabilitation beds and these patients may require very different care. It is not uncommon for "slow stream" rehabilitation beds to be in the same ward as continuing care beds, but it does

require much broader range of care to meet the medical and social needs of these patients. I would anticipate that some patients would move from the slow stream rehabilitation to continuing care category. Dr Lord describes the existence of fortnightly multidisciplinary ward case conference suggesting there was a structured team approach that would have made Dr Barton and nursing staff aware of rehabilitation needs of patients. In Mrs Richards's case no such case conference took place because she became too unwell in a short period. Third Dr Barton may not have received sufficient training or gained adequate experience of rehabilitation or geriatrics despite working under the supervision of Dr Lord. Dr Lord states that Dr Barton was "*an experienced GP*" who had rights of admission to a GP ward and that Dr Lord had admitted patients "*under her care say for palliative care*". Experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

2.19 The assessment of Mrs Richard's agitation the following day on 12th August was in my opinion sub-optimal. The nursing records state that she did not appear to be in pain. There is no entry from Dr Barton this day but in her statement she states which I have some difficulty in interpreting: "*When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totalling 20mg over the first 24 hours and 10mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure*".

2.20 I am unable establish from the notes and Dr Barton's statement whether she saw Mrs Richards in pain after she wrote in the notes and then wrote up the opiate drugs later on the 11th August, or if she wrote up these drugs after seeing her when she was not in pain, because she considered she might develop pain and agitation. In either case there is no evidence that the previous information provided by Sergeant Curran that Mrs Richards usually required the toilet when she was agitated was considered by Dr Barton. Screaming is a well-described behavioural disturbance in dementia (Dr Barton was clearly aware of this), which can be due to pain but is often not. In some cases it is not possible to identify a clear precipitating cause although a move to a new ward could precipitate such a behavioural disturbance. I would consider the assumption by Dr Barton that Mrs Richards screaming was due to pain was not supported by her own recorded observations. There is no evidence from the notes that Dr Barton examined Mrs Richards in the first two days to find any evidence on clinical examination that pain from her hip was the cause of her screaming. If the screaming had been worse on weight bearing or movement of the hip this would have provided supportive evidence that her screaming was

due to hip pain. Staff Nurse Jennifer Brewer in her interview with DC Colvin and DC McNally states that the nursing staff had considered the need for toileting and other potential causes of Mrs Richards screaming.

2.21 Mrs Richards pain following surgery had been controlled at Haslar hospital by intermittent doses of intravenous morphine and then intermittent doses of cocodamol (paracetamol and codeine phosphate). Dr Barton did not prescribe cocodamol or another mild or moderate analgesic to Mrs Richards to take on a prn basis when she was transferred. This makes me consider it probable that Dr Barton prescribed prn Oramorph, diamorphine, hyoscine and midazolam when she first saw Mrs Richards and she was not in pain. If this is the case it is highly unusual practice in a patient who has been transferred for rehabilitation, was not taking any regular or intermittent analgesics for 36 hours prior to transfer, and had last taken two tablets of cocodamol. In a rehabilitation or continuing care ward without resident medical staff I would consider it reasonable and usual practice to prescribe a mild or moderate analgesic to take on an as required basis in case further pain developed. In Mrs Richards's case a reasonable choice would have been cocodamol since she had been taking this a few days earlier without problems. I do not consider it was appropriate to administer intermittent doses of oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. It is not appropriate to prescribe powerful opiate drugs as a first line treatment for pain not clearly due to a fracture or dislocation to a patient such as Mrs Richards 12 days following surgery. Dr Barton'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.

2.22 The management of Mrs Richards when sustained a dislocation of her hip on 13th August was in my opinion sub-optimal. The hip dislocation most likely occurred following the fall from her chair at 1330h. The nursing notes suggest signs of a dislocation were noted at 1930h. If there was a delay in recognising the dislocation I would not consider this indicates poor care, as hip fractures and dislocations can be difficult to detect in patients who have dementia and communication difficulties. Mrs Richards suspected dislocation or fracture was discussed with the on-call doctor, Dr Briggs, who I would assume is a medical house officer. Given the concern about a fracture or dislocation I would judge it would have been preferable for her to b transferred to the orthopaedic ward that evening and be assessed by the orthopaedic team. I certainly consider the case should have been discussed with either the on call consultant geriatrician or the orthopaedic team. The benefits of transfer that evening in a patient where it was highly probable a fracture or dislocation were present would have been Mrs Richards could have received manipulation earlier the following morning and possibly that same evening, and that traction could have been applied even if reduction was not attempted.

2.23 Mrs Richards was found to have a dislocation of her right hip and this was manipulated under intravenous sedation the same day. Although she was initially unresponsive, most probably due to prolonged effects of the intravenous midazolam, 3 days later on 17th August she was mobilising and fully weight bearing and not requiring any analgesia. Although there are few medical note entries, the management at Haslar hospital during this period

appears to be appropriate and competent. Shortly after transfer back to Daedalus ward Mrs Richards again became very distressed. The nursing notes indicate there was an incorrect transfer by the ambulance staff of Mrs Richards onto her bed. Repeat dislocation of the right hip was reasonably suspected but not found on a repeat Xray. My impression is that this transfer may have precipitated hip or other musculoskeletal pain in Mrs Richards but that other causes of screaming were possible.

2.24 Intermittent doses of oral morphine were first administered to Mrs Richards, again without first determining whether less powerful analgesics would have been helpful. On 18th August Dr Barton suggested commencing subcutaneous diamorphine, haloperidol and midazolam. The diamorphine and midazolam had been prescribed 7 days earlier. An infusion of the three drugs was commenced later that morning and hyoscine was added on 19th August. Both Dr Barton's notes and the nursing notes indicate Mrs Richards was in pain, although it is not clear what they considered was the cause of the pain at this stage, having excluded a fracture or dislocation of the right hip. Dr Barton states in her prepared statement "*... it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated*".

2.25 Although there are no clear descriptions of Mrs Richard's conscious 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 also seems that she was not offered fluids or food and intravenous or subcutaneous fluids were not considered as an alternative. My interpretation is that this was most probably because medical and nursing staff were of the opinion that Mrs Richards were dying and that provision of fluids or nutrition would not change this outcome. In her prepared statement Dr Barton states "*As their mother was not eating or drinking or able to swallow, subcutaneous infusion of pain killers was the best way to control her pain.*" and "*I was aware that Mrs Richards was not taking food or water by mouth*". She then goes on to say "*I believe I would have explained to the daughters that subcutaneous fluids were not appropriate*".

Evaluation of drugs prescribed and the administration regimens

2.26 The decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards initial admission to Daedalus ward was in my opinion inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression. The prescription of oral paracetamol, mild opiates such as codeine or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen would have been appropriate oral and preferable with a better risk/benefit ratio. The prescription of subcutaneous diamorphine, haloperidol and midazolam infusions to be taken if required was inappropriate even if she was experiencing pain. Subcutaneous opiate infusions should be used only in patients whose pain is not controlled by oral analgesia and who cannot swallow oral opiates. The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards 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 effects 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 a high risk of producing respiratory depression or coma.

2.27 I consider the statement by Dr Barton "*my use of midazolam in the dose of 20mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of haloperidol to that which she had been having orally since her first admission.*" Indicates poor knowledge of the indications for and appropriate use of midazolam administered by subcutaneous infusion to older people. Midazolam is primarily used for sedation and is not licensed for use as a muscle relaxant. Doses of benzodiazepine that produce significant muscle relaxation in general produce unacceptable depression of conscious level, and it is not usual practice amongst continuing care and rehabilitation wards to administer subcutaneous midazolam to assist moving patients.

Quality and sufficiency of the medical records

2.28 The medical and nursing records relating to Mrs Richards admissions to Daedalus ward are in my opinion not of an adequate standard. The medical notes fail to adequately account for the reasons why oramorph and then infusions of diamorphine and haloperidol were used. The nursing records do not adequately document hydration and nutritional needs of Mrs Richards during her admissions to Daedalus ward.

Appropriateness and justification of the decisions that were made

2.29 There are a number of decisions made in the care of Mrs Richards 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.

Recorded cause of death

2.30 The recorded cause of death was bronchopneumonia. I understand that the cause of death was discussed with the coroner. A post mortem was not obtained and the recorded cause was certainly a possible cause of Mrs Richards's death. I am surprised the death certificate makes no mention of Mrs Richards's fractured neck of femur or her dementia. It is possible that Mrs Richards died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mrs Richards was at high risk of developing pneumonia because of the immobility that resulted following her transfer back to Daedalus ward even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia was possible. However given the rapid decline in

conscious level that preceded the development of respiratory symptoms (rattly chest) I would consider it more likely that Mrs Richards became unconscious because of the sedative and opiate drugs she received by subcutaneous infusion, that these drugs caused respiratory depression and that Mrs Richards died from drug induced respiratory depression and/or without bronchopneumonia resulting from immobility or drug induced respiratory depression. There are no accurate records of Mrs Richards respiratory rate but with the doses used and her previous marked sedative response to intravenous midazolam it is highly probable that respiratory depression was present.

Duty of care issues

2.31 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care to attempt to monitor Mrs Richards and to document the effects of drugs prescribed. In my opinion this duty of care was not adequately met. The prescription of diamorphine, midazolam and haloperidol was extremely hazardous and Mrs Richards was inadequately monitored. The duty of care of the medical and nursing staff to meet Mrs Richard's hydration and nutritional needs was also in my opinion probably not met.

Summary

2.32 Gladys Richards 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 Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Baron. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her heath and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Arthur "Brian" CUNNINGHAM

Course of Events

3.1 Mr Cunningham was 79 years old when admitted to Dryad ward, Gosport Hospital under the care of Dr Lord. Dr Lord had assessed him on a number of occasions in the previous 4 years. A letter dated 2nd December 1994 from Dr Bell, Clinical Assistant, indicates Parkinson's disease had been diagnosed in the mid 1980s and that he was having difficulties walking at this time. In 1998 it was noted he had experienced visual hallucinations and had moved into Merlin Park Rest Home. His weight was 69Kg in August 1998. In July 1998 he was admitted under the care of Dr Banks, Consultant in Old Age Psychiatry to Mulberry Ward A and discharged after 6 weeks to Thalassa Nursing Home. He was assessed to have Parkinson's disease and dementia, depression and myelodysplasia. Dr Lord in a letter dated 1 September 1998 summarises her assessment of Mr Cunningham when she saw him on Mulberry Ward A on 27 August 1998 before he was discharged to Thalassa Nursing Home. At this time he required 1-2 people to transfer and was unable to wheel himself around in his wheelchair. She commented that more levodopa might be required but was concerned it would upset his mental state. She arranged to review him at the Dolphin Day Hospital.

3.2 On 21st September 1998 he was seen at the Dolphin Day Hospital by Dr Lord who recorded *'very frail, tablets found in mouth, offensive large necrotic sacral sore with thick black scar. PD - no worse. Diagnoses listed as sacral sore (in N/H), PD, old back injury, depression and element of dementia, diabetes mellitus –diet, catheterised for retention. Plan – stop codanthramer and metronidazole. looks fine. TCI Dyad today –aserbine for sacral ulcer – nurse on side – high protein diet – oramorph prn if pain. N/Home to keep bed open for next 3/52 at least. Pt informed of admission agrees. Inform N/Home Dr Banks and social worker. Analgesics prn.'* He was admitted to Dyad ward. An entry by Dr Baron on 21 September states *'make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death'.* On 24th September Dr Lord has written *'remains unwell. Son has ??? again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death.'* The next entry by Dr Brook is on 25th September *'remains very poorly. On syringe driver. For TLC'.*

3.3 Medication charts record the following administration of opiate and sedative drugs:

21 Sep 1415h Oramorph 5mg
1800h Coproxamol two tablets
(subsequent regular doses not administered)
2015h Oramorph10mg
21 Sep 2310h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
22 Sep 2020h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
23 Sep 0925h Diamorphine 20mg/24hr, hyoscine 200microg/24hr midazolam 20 mg/24hr infusion sc
2000h Diamorphine 20mg/24hr, hyoscine 200microg/24hr midazolam 60mg/24hr infusion sc
24 Sep 1055h Diamorphine 20mg/24hr, hyoscine 800microg/24hr midazolam 80mg/24hr infusion sc
25 Sep 1015h Diamorphine 60mg/24hr, hyoscine 1200mg/24hr

midazolam 80mg/24hr infusion
26 Sep 1150h Diamorphine 80mg/24hr, hyoscine 1200mg/24hr
midazolam 100mg/24hr infusion
Sinemet 110 5 times/day was discontinued on 23rd September

3.4 The nursing notes relating to the admission to Dyad ward record on 21st Sept *'remained agitated until approx 2030h. Syringe driver commenced as requested* (unclear who made this request) *diamorphine 20mg, midazolam 20mg at 2300. Peaceful following".* On 22nd Sep *'explained that a syringe driver contains diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode where Arthur tried to wipe sputum on a nurse saying he had HIV and going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself.'*

3.5 On 23rd Sep *'Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked is this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed.'* A later entry *'now fully aware that Brian is dying and needs to be made comfortable. Became a little agitated at 2300h, syringe driver adjusted with effect. Seems in some discomfort when moved, driver boosted prior to position change'.* On 24th Sept *'report from night staff that Brian was in pain when attended to, also in pain with day staff – especially his knees. Syringe driver renewed at 1055".* On 25th Sept *'All care given this am. Driver recharged at 1015 –diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50mmols/hr. Peaceful night - unchanged, still doesn't like being moved.'* On 26th September *'condition appears to be deteriorating slowly'.*

3.6 On 26th September staff nurse Tubbritt records death at 2315h. Cause of death was recorded on the death certificate as bronchopneumonia with contributory causes of Parkinson's disease and Sacral Ulcer.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

3.7 Primary responsibility for the medical care of Mr Cunningham during his last admission lay with Dr Lord, as the consultant responsible for his care. She saw Mr Cunningham 5 days before his death in the Dolphin Day Hospital, and 2 days before his death on Dyad ward. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Cunningham and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

3.8 Initial assessment by Dr Lord was comprehensive and appropriate with a clear management plan described. The nursing staff record Mr Cunningham was agitated following admission on 21st September. Dr Lord had prescribed prn (intermittent as required) oramorph for pain. Nursing staff made the decision to administer oramorph but there is no clear recording in the nursing notes that he

was in pain or the site of pain. The nursing entry on 22nd Sept indicates a syringe driver was commenced for 'pain relief and to allay anxiety. Again the site of pain is not states. My interpretation of the records is that the nursing staff considered his agitation was due to pain from his sacral ulcer. The medical and nursing teams view on the cause of Mr Cunningham's deterioration on 23rd September when he became 'chesty' are not explicitly stated, but would seem to have been thought to be due to bronchopneumonia since this was the cause of death later entered on the death certificate. The medical and nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression. The nursing staff filed to appreciate that the agitation Mr Cunningham experienced on 23rd Sept at 2300h may have been due to the midazolam and diamorphine. It was appropriate for nursing staff to discuss Mr Cunningham's condition with medical staff at this stage.

3.9 When Dr Lord reviewed Mr Cunningham on 24th September the notes imply that he was much worse that when she had seen him 3 days earlier. There is clear recording by Dr Lord that Mr Cunningham was in pain. The following day the diamorphine dose was increased three fold from 20mg/24hr to 60mg/24hr and the dose was further increased on 26th September to 80mg/24hr although the nursing and medical notes do not record the reason for this. The notes suggest that the nursing and medical staff may have failed to consider causes of agitation other than pain in Mr Cunningham or to recognise the adverse consequences of opiates and sedative drugs on respiratory function in frail older individuals.

Evaluation of drugs prescribed and the administration regimens

3.10 The prescription of oramorph to be taken 4 hourly as required by Mr Cunningham was reasonable if his pain was uncontrolled from cocodamol. I consider the decision by Dr Barton 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 Dr Lord that he should be prescribed intermittent (underlined instruction) doses of oramorph earlier in the day. I consider the undated prescription by Dr Baron of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr 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 Mr Cunningham. 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.

3.11 In my opinion it is doubtful the nursing and medical staff understood that when a syringe infusion pump rate is increased it takes an often appreciable effect of time before the maximum effect of the increased dose rate becomes evident. Typically the time period would be 5 drug half-lives. In the case of diamorphine this would be between 15 and 25 hours in an older frail individual.

Quality and sufficiency of the medical records

3.12 In my opinion the medical and nursing records are inadequate following Mr Cunningham's admission to Dryad ward. The initial assessment by Dr Lord on 21st September is in my opinion competent and appropriate. The medical notes following this are inadequate and do not explain why he was commenced on subcutaneous infusions of diamorphine and midazolam. The nursing notes are variable and at times inadequate.

Appropriateness and justification of the decisions that were made

3.13 An inappropriately high dose of diamorphine and midazolam was first prescribed. There was a failure to recognise or respond to drug induced problems. Inappropriate dose escalation of diamorphine and midazolam and poor assessment by Dr Lord. The assessment by Dr Lord on 21st September 1998 was thorough and competent and a clear plan of management was outlined. There is a clear note by Dr Lord that oramorph was to be given intermittently (PRN) for pain and not regularly. It is not clear from the medical and nursing notes why Mr Cunningham was not administered the regular cocodamol he was prescribed following the initial dose he received at 1800h following admission. It is good practice to provide regular oral analgesia, with paracetamol and a mild opiate, particularly when a patient has been already taking this medication and to use prn morphine for breakthrough pain. I consider the prescription by Dr Barton on admission of prn subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be unjustified, poor practice and potentially very hazardous. It is particularly notable that only hours earlier Dr Lord had written that oramorph was to be given intermittently and this had been underlined in the medical notes. There is no clear justification in the notes for the commencement of subcutaneous diamorphine and midazolam on the evening following admission. If increased opiate analgesia was required increasing the oramorph dose and frequency could have provided this. I would judge it poor management to initially commence both diamorphine and midazolam. 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.

3.14 I am concerned by the initial note entry by Dr Barton on 21st September 1998 that she was happy for nursing staff to confirm death. There was no indication by Dr Lord that Mr Barton was expected to die, and Dr Barton does not list the reason she would have cause to consider Mr Cunningham would die within the next 24 hours before he was reviewed the following day by medical staff. In my opinion it is of concern that the nursing notes suggest the diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded in the nursing entry on 22nd September.

3.15 Hyoscine was commenced on 23rd September after Mr Cunningham had become 'chesty' overnight. I consider it very poor practice that there is no record of Mr Cunningham being examined by a doctor following admission on 21st September, and a decision to treat this symptomatically with hyoscine appears to have been made by the medical staff. At this stage Mr Cunningham's respiratory signs are likely to have been due to bronchopneumonia or respiratory depression resulting in depressed clearance of bronchial secretions. A medical assessment was very necessary at this

stage to diagnose the cause of symptoms and to consider treatment with antibiotics or reduction in the dose of diamorphine and midazolam.

3.16 Again I consider it very poor practice that the midazolam was increased from 20mg/24hr to 60mg/24 hr at 2000h on 23rd September. There is no entry in the medical notes to explain this dose increase. The decision to triple the midazolam dose appears to have been made by a member of nursing staff as the nursing notes record "*agitated at 2300h, syringe driver boosted with effect*".

3.17 A medical assessment should have been obtained before the decision to increase the midazolam dose was made. At the very least Mr Cunningham's problems should have been discussed with on call medical staff. Mr Cunningham's agitation may have been due to pain, where increasing analgesia would have been appropriate, or hypoxia (lack of oxygen). If Mr Cunningham's agitation was due to hypoxia a number of interventions may have been indicated. Reducing the diamorphine and midazolam dose would have been appropriate if hypoxia was due to respiratory depression. Commencement of oxygen therapy and possibly antibiotics would have been appropriate if hypoxia was due to pneumonia. Reducing the dose diamorphine or midazolam would have been indicated if hypoxia was due to drug-induced respiratory depression. The decision to increase the midazolam dose was not appropriately made by the ward nursing staff without discussion with medical staff.

3.18 When Mr Cunningham was reviewed by Dr Lord on 24th September he was very unwell but there is not a clear description of his respiratory status or whether he had signs of pneumonia. At this stage Dr Lord notes Mr Cunningham is in pain, but does not state the site of his pain. It is not clear to me whether the subsequent alteration in infusion rate of diamorphine, hyoscine and midazolam was discussed with and sanctioned by Dr Lord or Dr Barton. I consider the increase in midazolam from 60mg/24 hr to 80mg/24 hr was inappropriate as a response to the observation that Mr Cunningham was in pain. It would have been more appropriate to increase the diamorphine dose or even consider treatment with a non-steroidal anti-inflammatory drug. The increase in midazolam dose to 80mg/24 hr would simply make Mr Cunningham less conscious than he already appears to have been (there is not a clear description of his conscious level at this stage).

3.19 The increase in hyoscine dose to 800microg/24 hr is also difficult to justify when there is no record that the management of bronchial secretions was a problem. The subsequent threefold increase in diamorphine dose later that day to 60mg/24 hr is in my view very poor practice. Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death. The description of Mr Cunningham, was that analgesia was 'just' controlling pain and a more cautious increase in diamorphine dose, certainly no more than two fold, was indicated with careful review of respiratory status and conscious level after steady state levels of diamorphine would have been obtained about 20 hours later. A more appropriate response to deal with any acute breakthrough pain is to administer a single prn (intermittent) dose of opiate by the oral or intramuscular route, depending on whether Mr Cunningham was unable to swallow at this time.

3.20 The increase in both diamorphine dose and midazolam dose on 26th September is difficult to justify when there is no record in the medical or nursing notes that Mr Cunningham's pain was uncontrolled. Although it is possible to accept the increase in diamorphine dose may have been appropriate if Mr Cunningham was observed to be in pain, I find the further increase in midazolam dose to 100mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80mg/24hr of diamorphine would be virtually certain to produce respiratory depression and severe depression of conscious level. This would be expected to result in death in a frail individual such as Mr Cunningham. I would expect to see very clear reasons for the use of such doses recorded in the medical notes.

3.21 I can find no record of Mr Cunningham receiving food or fluids following his admission on 21st September despite a note from Dr Lord that Mr Cunningham was to receive a 'high protein diet'. There is no indication in the medical or nursing notes as to whether this had been discussed, but given that Mr Cunningham was admitted with the intention of returning to his Nursing Home (it was to be held open for 3 weeks) I would expect the notes to record a clear discussion and decision making process involving senior medical staff accounting for the decision to not administer subcutaneous fluids and/or nasogastric nutrition once Mr Cunningham was commenced on drugs which may have made him unable to swallow fluids or food.

Recorded causes of death

3.22 The recorded cause of death was bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer. A post mortem was not obtained and the recorded causes were in my opinion reasonable. It is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mr Cunningham was at high risk of developing pneumonia even if he had not received sedative or opiate drugs, bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia as reasonable. Even if the staff had considered Mr Cunningham had drug-induced respiratory depression as a contributory factor, it would not be usual medical practice to enter this as a contributory cause of death where the administration of such drugs was considered appropriate for symptom relief.

Duty of care issues

3.23 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care to attempt to heal Mr Cunningham's sacral ulcer and to document the effects of drugs prescribed. In my opinion this duty of are was not adequately met and the denial of fluid and diet and prescription of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham's death.

Summary

3.24 In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham 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 hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham 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.

ALICE WILKIE

Course of Events

4.1 Alice Wilkie was 81 years old when admitted under the care of Dr Lord, by her general practitioner on 31st July 1998 from Addenbrooke Rest Home to Phillip Ward, Department of Medicine for Elderly People, at the Queen Alexandra Hospital, Portsmouth. The general practitioner referral letter states "*This demented lady has been in this psychogeriatric care home for a year. She had a UTI early this week and has not responded to trimethoprim. Having fallen last night, she is not refusing fluids and is becoming a little dry*." The medical admitting notes record she was taking prozac (fluoxetine) syrup 20 mg once daily, codanthramer 5-10ml nocte, lactulose 10ml once daily zopiclone 1.875 or 3.75mg nocte and promazine syrup 25mg as required. On examination she had a fever and bilateral conjunctivitis but no other significant findings. The admitting doctor diagnosed a urinary tract infection and commenced intravenous antibiotics to be administered after a blood culture and catheter specimen of urine had been obtained. The following day DNR (do not resuscitate) is recorded in the notes. On 3rd August 1998 the medical notes record the fever had settled, that she was taking some fluids orally, was taking the antibiotic Augmentin elixir orally and receiving subcutaneous fluids. The notes then record (date not clear) that her Mental Test Score was 0/10 and Barthel 1/20 (indicating severe dependency). Mrs Wilkie was to be transferred to Daedalus NHS continuing care ward on 6th August 1998 with a note that her bed was to be kept at Addenbrooke Rest Home.

4.2 Following transfer on 6th August an entry in the medical notes states "*Transferred from Phillips Ward. For 4-6/52 only. On Augmentin for UTI*". Dr Lord writes on 10th August 1998 '*Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrooke's. R/V* (review) *in 1/12* (one month) *–if no specialist medical or nursing problems D* (discharge) *to a N/Home. Stop fluoxetine*'. The next entry is by Dr Barton on 21st August "*Marked deterioration over last few days. sc analgesia commenced yesterday. Family aware and happy*". The final entry is on the same day at 1830h where death is confirmed. The most recent record of the patient's weight I can find is 56Kg in April 1994.

4.3 The nursing notes, which have daily entries during her one week stay on Phillip ward note she was catheterised, was confused at times and was sleeping well prior to transfer. The nursing notes on Daedalus ward record "6/8/98 *Transferred from Philip ward QAH for 4-6 weeks assessment and observation and then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration*" and that she was seen by Dr Peters. The nursing assessment sheet notes "*does have pain at times unable to ascertain where*". The nutrition care plan states on 6th August 1998 "*Due to dementia patient has a poor dietary intake*". And dietary intake is recorded between 12th August and 18th August but not before or following these dates. Nursing entries in the contact record state on 17th August 1998 "*Condition has generally deteriorated over the weekend Daughter seen- aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain*". There is no entry in the notes on 20th August or preceding few days indicating Mrs Wilkie was in pain.

4.4 A nursing entry on 21st August 1998 at 1255h states "*Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free*". There are a number of routine entries in the period 6th August 1998 to death on 21st August 1998 in nutrition, pressure area care, constipation, catheter care, and personal hygiene. The nursing care plan records no significant deterioration until 21st August where it is noted death was pronounced at 2120h by staff nurse Sylvia Roberts. Cause of death was recorded as bronchopneumonia.

4.5 The drug charts records that Dr Barton prescribed as a regular daily review (not intermittent as required) prescription diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr all to be administered subcutaneously. The prescription is not dated. Drugs were first administered on 20th August, diamorphine at 30mg/24hr and midazolam 20mg/24hr from 1350h and then again on 21st August. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her admission to Daedalus ward prior to administration of the diamorphine and midazolam infusions. During the period 16th-18th August she was prescribed and received zopiclone (a sedative hypnotic) 3.75mg nocte and co-danthramer 5-10ml (a laxative) orally.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

4.6 Primary responsibility for the medical care of Mrs Wilkie during her admission to Daedalus ward lay with Dr Lord, as the consultant responsible for her care. She saw Mrs Wilkie on 10th August 1998, 11 days prior to her death. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Wilkie and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

4.7 The initial diagnosis of a urinary tract infection and dehydration was reasonable and appears correct. Mrs Wilkie had a diagnosis of dementia, which there was clear evidence for. The entry by Dr Lord on 10th August 1998 provides a reasonable assessment of her functional level at this time, and a plan to review appropriate placement in one month's time. No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15th August. There is no medical assessment in the notes following 10th August except documentation on 21st August 1998 of a marked deterioration. There is no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics.

Evaluation of drugs prescribed and the administration regimens

4.8 No information is recorded in the medical or nursing notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In my opinion there was no indication for the use of diamorphine and hyoscine in Mrs Wilkie. Other oral analgesics, such as paracetamol and mild opiate drugs could and should first have been tried, if Mrs Wilkie was in pain, although there is no evidence that she was. If these were inadequate oral morphine would have

been the next appropriate choice. From the information I have seen in the notes it appears the diamorphine and midazolam may have been commenced for non-specific reasons, perhaps as a non-defined palliative reasons as it was judged she was likely to die in the near future.

4.9 I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. 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.

Quality and sufficiency of the medical records

4.10 The medical and nursing records during her stay on Daedalus ward are inadequate not sufficiently detailed, and do not provide a clear picture of Mrs Wilkie's condition. In my opinion the standard of the notes falls below the expected level of documentation on a continuing care or rehabilitation ward. The assessment by Dr Lord on 10th August 1998 is the only satisfactory medical note entry during her 15 day stay on Daedalus ward.

Appropriateness and justification of the decisions that were made

4.11 As discussed above I do not consider the decision to commence diamorphine and hyoscine was appropriate on the basis of the information recorded in the clinical notes.

Recorded causes of death

4.12 There was no specific evidence that bronchopneumonia was present, although this is a common pre-terminal event in frail older people, and is often entered as the final cause of death in frail older patients. I am surprised the death certificate did not apparently refer to Mrs Wilkie's dementia as a contributory cause. It is possible Mrs Wilkie's death was due at least in part to respiratory depression from the diamorphine she received, or that the diamorphine led to the development of bronchopneumonia. However since there are no clear observations of Mrs Wilkie's respiratory observations it is difficult to know whether respiratory depression was present Mrs Wilkie deteriorated prior to administration of diamorphine and midazolam infusion, and in view of this, my opinion would be that although the opiate and sedative drugs administered may have hastened death, and these drugs were not indicated, Mrs Wilkie may well have died at the time she did even if she had not received the diamorphine and midazolam infusions.

Duty of care issues

4.13 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care, to monitor, and to document the effects of drugs prescribed to Mrs Wilkie. In my opinion this duty of care was not adequately met, the prescription of diamorphine and midazolam was poor practice and this may have contributed to Mrs Wilkie's death.

Summary

4.14 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. However Mrs Wilkie 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 and opiate drugs.

Robert WILSON

5.1 Mr Wilson was 75 years old man when he was admitted to Queen Alexandra Hospital on 22nd September 1998 after he sustained a proximal fracture of the left humerus. He was treated with morphine, initially administered intravenously and then subcutaneously. He developed vomiting. On 24th September he was given 5mg diamorphine and lost sensation in the left hand. On 29th September an entry in the medical notes states "*ref to social worker, review resus status. Not for resuscitation in view of quality of life and poor prognosis*".

5.2 On 7th October the notes record he was "*not keen on residential home and wished to return to his own home*". Dr Lusznat, Consultant in Old Age Psychiatry on 8th October 1998, saw him. Dr Lusznat's letter on 8th October notes that Mr Wilson had been sleepy and withdrawn and low in mood but was now eating and drinking well and appeared brighter in mood. His Barthel score was 5/20. Dr Lusznat noted he had a heavy alcohol intake during the last 5 years. At the time he was seen by Dr Lusznat her was prescribed thiamine 100 mg daily, multivitamins two tablets daily, senna two tablets daily, magnesium hydroxide 10 mls twice daily and paracetamol 1g four time daily. On examination he had mildly impaired cognitive function (Mini Mental State Examination 24/30). Dr Lusznat considered Mr Wilson might have developed an early dementia, which could have been alcohol related, Alzheimer's disease or vascular dementia. An antidepressant trazadone 50mg nocte was commenced. Dr Lusznat states at the end of her letter "*On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged*". On 13th October the medical notes record a ward round took place, that he required both nursing and medical care, was at risk of falling and that a short spell in long-term NHS care would be appropriate. Reviewing the drug charts Mr Wilson was taking regular soluble paracetamol (1g four times daily) and codeine phosphate 30mg as required for pain. Between 8th and 13th October Mr Wilson was administered four doses of 30mg codeine. Mr Wilson's weight in March 1997 was 93Kg

5.3 On the 14th October Mr Wilson was transferred to Dryad Ward. An entry in the medical notes by Dr Barton reads "*Transfer to Dryad ward continuing care. HPC fracture humerus. needs help with ADL* (activities of Daily Living)*, hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation*". On 16th November the notes record; '*Decline overnight with S.O.B. o/e ? weak pulse. Unresponsive to spoken work. Oedema ++ in arms and legs. Diagnosis ?silent MI, ? decreased __ function. ↑frusemide to 2 x 40mg om* '. On 17th October the notes record '*comfortable but rapid deterioration*'. On 18th October staff nurse Collins records death at 2340h. Cause of death is recorded as congestive cardiac failure.

5.4 Nursing notes state in the summary section on 14th October "*History of left humerus fracture, arm in collar and cuff. Long history of heavy drinking. LVF chronic oedematous legs. S/B Dr Barton. Oramorph 10mg/5ml given. Continent of urine – uses bottles*". On 15th October "*Commenced oramorph 10mg/5ml 4 hrly for pain in L arm. Wife seen by sis. Hamblin who explained Robert's condition is poor*". An earlier note states "*settled and slept well*". On 16th October "*seen by Dr Knapman an as deteriorated over night. Increase*

*frusemide to 80mgdaily. For A.N.C (*active nursing care*)*". Later that day a further entry states "*Patient very bubbly chest this pm. Syringe driver commenced 20mg diamorphine, 400mcgs hyoscine. Explained to family reason for driver*". A separate note on 16th October in the nursing care plan states "*More secretions – pharyngeal – during the night, but Robert hasn't been distressed. Appears comfortable*". On 17th October 0515h "*Hyoscine increased to 600mcgs as oro-pharyngeal secretions increasing. Diamorphine 20mg.*" Later that day a further entry states "*Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver reviewed at 15.50 s/c diamorphine 40mg, midazolam 20mcgs, hyoscine 800 mcgs*". A later note states "*night: noisy secretions but not distressing Robert. Suction given as required during night. Appears comfortable*". On 18th October "*further deterioration in already poor condition. Syringe driver reviewed at 14:40 s/c diamorphine 60mg, midazolam 40mg, hyoscine 1200mcg. Continues to require regular suction*".

5.5 The medication charts record administration of the following drugs:
14 Sep 1445h oramorph 10mg
2345h oramorph 10mg
16 Sep 1610h diamorphine 20mg/24 hr, hyoscine 400 microg/24hr subcutaneous infusion
17 Sep 0515h diamorphine 20mg/24hr, hyoscine 600 microg/24hr
1550h diamorphine 40mg/24hr, hyoscine 800 microg/24hr midazolam 20mg/24hr
18 Sep 1450h diamorphine 60mg/24hr, hyoscine 1200 microg/24hr midazolam 40mg/24hr
Frusemide was administered at a dose of 80mg daily at 0900h on 15th and 16th October. An additional 80 mg oral dose was administered at an unstated time on 16th October..

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

5.6 Responsibility for the care of Mr Wilson during his admission to Dryad ward lay with Dr Lord as the consultant responsible for his care. My understanding is that day to day medical care was delegated to the clinical assistant Dr Barton and during the out of hours responsibility was with the on call doctor based at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Wilson and informing medical staff of any significant deterioration.

5.7 Dr Lusznat was responsible for assessing Mr Wilson and making further recommendations concerning his future care when he was seen at Queen Alexandra Hospital.

Accuracy of diagnosis and prognosis including risk assessments

5.8 Dr Barton assessed Mr Wilson on 14th October the day he was transferred to Dyad ward. There was a plan to attempt to improve his mobilisation through rehabilitation. There is no record of any significant symptomatic medical problems, in particular any record that Mr Wilson was in pain in the medical

notes. The nursing notes suggest Mr Wilson was prescribed oramorph for pain in his arm following his admission to Dryad Ward. He was prescribed paracetamol to take as required but did not receive any paracetamol whilst on Dryad Ward.

5.9 Mr Wilson deteriorated on 15th September when he became short of breath. The working diagnosis was of heart failure due to a myocardial infarct. I do not consider the assessment by the on call doctor of Mr Wilson was adequate or competent. There is no record of his blood pressure, clinical examination findings in the chest (which might have indicated whether he had signs of pulmonary oedema or pneumonia). In my opinion an ECG should have been obtained that night, and a Chest Xray obtained the following morning to provide supporting evidence for the diagnosis. Mr Wilson was admitted for rehabilitation not terminal care and it was necessary and appropriate to perform reasonable clinical assessments and investigations to make a correct diagnosis.

5.10 Following treatment Mr Wilson was noted to have had a rapid deterioration. The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion. In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued. The nursing and medical staff failed to record Mr Wilson's respiratory rate, which was likely to have been reduced, because of respiratory depressant effects of the diamorphine. The diamorphine and hyoscine infusion should have been discontinued to determine whether this was contributing to his deteriorating state. There is no record of the reason for the prescribing of the midazolam infusion commenced the day before his death. At this time the nursing notes record he was comfortable. Mr Wilson did not improve. The medical and nursing teams did not appear to consider that the diamorphine, hyoscine and midazolam infusion could be a major contributory factor in Mr Wilson's subsequent decline. The infusion should have been discontinued and the need for this treatment, in my opinion unnecessary at the time of commencement, reviewed.

Evaluation of drugs prescribed and the administration regimens

5.11 The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate. His pain had been controlled with regular paracetamol and as required codeine phosphate (a mild opiate) prior to his transfer, and in the first instance these should have been discontinued.

5.12 I am unable to establish when Dr Barton wrote the prescription for subcutaneous diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr, and midazolam 20-80mg/24hr 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 Mr Wilson'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. Mr Wilson was not administered intravenous

frusemide or another loop diuretic. Instead only a single additional oral dose of frusemide was administered. In my opinion this was an inadequate response to Mr Wilson's deterioration. The prescription of continuous subcutaneous infusion of diamorphine and hyoscine is not appropriate treatment for a patient who is pain free with a diagnosis of a myocardial infarction and heart failure. When opiates are used to treat heart failure, close monitoring of blood pressure and respiratory rate, preferably with monitoring of oxygen saturation is required. This was not undertaken.

5.13 The increase in diamorphine dose to 40mg/24hr and then 60mg/24 hr in the following 48 hours is not appropriate when the nursing and medical notes record no evidence that Mr Wilson 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 40mg/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.

Quality and sufficiency of the medical records

5.14 The initial entry in the medical records by Dr Barton on 14th October is reasonable and sufficient. The subsequent entries relating to Mr Wilson's deterioration are in my opinion inadequate, and greater detail and the results of examination findings should have been recorded. No justification for the increases in diamorphine, midazolam and hyoscine dose are written in the medical notes. The nursing notes are generally of adequate quality but I can find no record of fluid and food intake by Mr Wilson.

Appropriateness and justification of the decisions that were made

5.15 I consider the prescription of oramorph was inappropriate. The subsequent prescription and administration of diamorphine, hyoscine and midazolam was highly inappropriate, not justified by information presented in the notes and could be expected to result in profound depression of conscious level and respiratory depression in a frail elderly man such as Mr Wilson.

Recorded causes of death

5.16 The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest Xray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However in my opinion it is highly likely that the diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Duty of care issues

5.17 Medical and nursing staff on Dryad ward had a duty of care to deliver appropriate medical and nursing care to Mr Wilson, and to monitor the effects of drugs prescribed. In my opinion this duty of care was not adequate. The administration of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Wilson's death.

Summary

5.18 Mr Wilson 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 doses 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.

Eva PAGE

6.1 Eva Page was 87 years old when admitted as an emergency on 6th February 1998 to the Department of Medicine for Elderly People at Queen Alexandra Hospital. The medical notes record that she had experienced a general deterioration over the last 5 days was complaining of nausea and reduced appetite and was dehydrated. She had felt 'depressed' during the last few weeks. On admission she was taking ramipril 5mg once daily (a treatment for heart failure and hypertension), frusemide 40mg once daily (treatment for fluid retention), digoxin 125microg once daily (to control irregular heart rate), sotalol 40 mg twice daily (to control irregular heart rate), aspirin 75 mg once daily (to prevent stroke and myocardial infarction) and sertraline 50mg once daily (an antidepressant commenced by her general practitioner on 26th January 1998). A discharge summary and medical notes relating to an admission in May 1997 states that she was admitted with acute confusion, had reduced movement on the right side and was discharged back to her residential home on aspirin. No admitting diagnosis is recorded in the clerking notes written by Dr Harris on 6th February 1998 but they record that *"patient refuses iv fluids and is willing to accept increased oral fluids*".

6.2 On 7th February 1998 the medical notes record an opacity seen on the chest Xray and sate "*mood low. Feels frightened – doesn't know why. Nausea and ??. Little else. Nil clinically."* An increased white cell count is noted (13.0) and antibiotics commenced. A subsequent chest Xray report (undated) states there is a 5cm mass superimposed on the left hilum highly suspicious of malignancy. The medical notes on 11 February 1998 record this at the Xray meeting. On 12th February 1998 the notes record (? Dr Shain) '*In view of advanced age aim in the management should be palliative care. Charles Ward is suitable. Not for CPR'.* On 13th February the notes record '*remains v low Appears to have 'given up' d/w son re probably diagnosis d/w RH (residential home) re ability to cope'.* The notes record *'son agrees not suitable for invasive Tx* (treatment*). Matron from RH visiting today will check on ability to cope.'*

6.3 On 19th February the notes record she fell on the ward and experienced minor cuts. On 16th February '*gradual deterioration, no pain, confused. For Charles Ward she could be discharged to community from Charles Ward'.* On 19th February the notes summarise her problems '*probable Carcinoma of the bronchus, previous left ventricular failure, atrial fibrillation, digoxin toxicity and a transient ischaemic attack, that she was sleepy but responsive, states that she is frightened but doesn't know why. Says she has forgotten things, not possible to elicit what she can't remember, low MTS (mental test score). Plan encourage oral fluids, s/c fluid over night if tolerated. Continue antidepressants*'. On 18th February the medical notes state "*No change. Awaiting Charles Ward bed*".

6.4 The nursing notes record she was confused but mobilised independently. On 19th February she was transferred to Charles Ward instead of the preferred option of a bed at Gosport Hospital, which the notes record was full ('no beds'). The Queen Alexandra Hospital medical notes record a summary of her problems on 19th February prior to transfer as follows " *Diagnosis CA bronchus probable [no histology] Diag based on CXR. PMH 95 LVF + AF 95 Digoxin toxicity 97 TIA. Admitted 6.2.98 general deterioration CXR ? Ca Bronchus.*

Well defined O lesion. Exam: sleepy but responsive answers appropriately. States that she is frightened but doesn't know why. Says she has forgotten things. Not possible to elicit what she can't remember. Low MTS" and *"Feels in general tired and very thirsty. Plan encourage oral fluids, s/c fluid overnight is tolerated continue antidepressants".*

6.5 The medical notes on 23rd February record diagnoses of depression, dementia, ? Ca bronchus, ischaemic heart disease and congestive heart failure. On 25th February Dr Lord records in the medical notes "*confused and some agitation towards afternoon – evening try tds* (three times daily) *thioridazine, son in Gosport, transfer to Gosport 27/2, heminevrin prn nocte'.* A further entry states *'All other drugs stopped by Dr Lord'.*

6.6 Mrs Page was transferred to Dryad ward at Gosport War Memorial Hospital on 27th February 1998. Dr Barton writes in the medical notes "*Transfer to Dryad ward continuing care, Diagnosis of Ca Bronchus on 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 state she was admitted for *'palliative care',* that she had a urinary catheter (inserted on 22nd February 1998) was incontinent of faeces, and was dependent for washing and dressing but could hold a beaker and pick up small amounts of food. Barthel Index was 2/20. The nursing action plan states *'encourage adequate fluid intake'.* On 28th February an entry in the medical notes by Dr Laing (duty GP) record *'asked to see: confused. Feels 'lost' agitated esp. night/evening, not in pain, to give thioridazine 25mg tds regular, heminevrin noct.* The nursing notes record she was very distressed and that she was administered thioridazine and Oramorph 2.5ml.

6.7 On 2nd March Dr Barton records *'no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain; Son to be seen by Dr Lord today'.* A subsequent entry by Dr Lord on the same day states *' spitting out thioridazine, quieter on prn sc diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present (diagnoses) 1) Ca Bronchus 2) ? Cerebral metastases. -ct* (continue) *fentanyl patches.'* A further entry by Dr Lord that day records *'son seen. Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue present plan of Mx* (management)".

6.8 On 2nd March the nursing notes record "*commenced on Fentanyl 25mcg this am. Very distressed this morning seen by Dr Barton to have and diamorphine 5mg i/m (intramuscular) same given 0810h by a syringe driver.* A further entry the same day states *"S/B Dr Lord. Diamorphine 5mg i/m given for syringe driver with diamorphine loaded".* On 3rd March a rapid deterioration in Mrs Page's condition is recorded *'Neck and left side of body rigid – right side rigid,* At 1050h diamorphine and midazolam were commenced by syringe driver. Death is recorded later that day at 2130h, 4 days following admission to Dyad ward.

6.9 The prescription charts (which are incompletely copied in notes made available to me) indicate she received the following drugs during this admission Two doses of intramuscular diamorphine 5 mg were administered at 0800 and 1500h (date not visible)

28 Feb 1998	1300h thioridazine 25mg
	1620h oramorph 5mg
	2200h heminevrin 250mg in 5ml
1 Mar 1998	0700h thioridazine 25 mg
	1300h thioridazine 25 mg
	2200h heminevrin 250mg
2 Mar 1998	0700h thioridazine 25mg
	0800h fentanyl 25microg
3 Mar 1998	1050h diamorphine 20mg/24hr, midazolam 20 mg/24hr by subcutaneous infusion

On 27th February Dr Barton prescribed thioridazine 25mg (prn tds) and Oramorph (10mg/5ml) 4hrly prn. On 2nd March Dr Barton prescribed fentanyl 25microg patch (x3 days) to take as required (prn). On 3rd March Dr Barton prescribed diamorphine 20-200mg/24hr, hyoscine 200-800ucg/24hr and midazolam 20-80mg/24hr by subcutaneous infusion.
The notes do not indicate that the fentanyl patch was removed and I would assume this was continued when the diamorphine and midazolam infusion was commenced.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

6.10 Primary responsibility for the medical care of Mrs Page during her admission to Dryad Ward lay with Dr Lord, as the consultant responsible for his care. She saw Mrs Page 2 days before her transfer to Dryad ward and two days following her admission, the day before she died. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Page and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

6.11 The assessment and management of Mrs Page at Alexandra Hospital was in my opinion competent and considered. From the information in the clinical notes I would agree with the diagnosis of probable carcinoma of bronchus. The decision to prescribe an antidepressant was in my opinion appropriate. Prior to transfer to Dryad ward she was not in pain but was transferred for palliative care. Although Mrs Page was clearly very dependent and unwell, it is not clear why Dr Barton prescribed opiates to Mrs Page on admission to Dryad ward when there is no evidence she was in pain. I suspect the reason was to provide relief for Mrs Page's anxiety and agitation. This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma. Mrs Page was noted to be severely dependent, Barthel Index 0, and in conjunction with a probable carcinoma of the bronchus the assessment that she required palliative care and was likely to die in the near future was appropriate.

Evaluation of drugs prescribed and the administration regimens

6.12 The prescription of the major tranquilliser thioridazine for anxiety was reasonable and appropriate. The prescribing of the sedative/hypnotic drug heminevrin was similarly reasonable although potential problems of sedation from the combination need to be considered. Mrs Page was not in pain but I consider the prescription of oramorph on 28th February to attempt to improve her distress was reasonable. By 2nd March Mrs Page remained very distressed despite prescription of Oramorph, thioridazine and heminevrin. Since the notes reported she was more settled following intramuscular diamorphine and she had been spitting out her oral medication, I would consider it appropriate to prescribe a transdermal fentanyl patch to provide continuing opioid drugs to Mrs Page. The lowest dose patch was administered but it would have been important to be aware of the potential for depression of respiration and/or conscious level that could occur.

6.13 I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd March when Mrs Page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. The notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.

Quality and sufficiency of the medical records

6.14 The medical and nursing records relating to Mrs Page's admission to Dryad ward are in my view of adequate quality, although as stated above the reasons for the use of midazolam and diamorphine are not recorded in either the medical or nursing notes.

Appropriateness and justification of the decisions that were made

6.15 In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death. From the information I have seen in the notes it appears that Dr Barton may have commenced the diamorphine and midazolam infusion for non-specific reasons or for non-defined palliative reasons when it was judged she was likely to die in the near future.

Recorded causes of death

6.16 In the absence of a post-mortem the recorded cause of death is reasonable. Mrs Page had a probable carcinoma of the bronchus and experienced a slow deterioration in her general health and functional abilities. It is possible that Mrs Page died from drug induced respiratory depression. However Mrs Page was at high risk of dying from the effects of her probable carcinoma of the bronchus even if she had not received sedative and opiate drugs. Bronchopneumonia

can also occur as a complication of opiate and sedative induced respiratory depression but also in patients deteriorating from malignancy. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mrs Page's respiratory rate I would consider the recorded cause of death was possible. The deterioration on between the 2nd March and 3rd March could have been secondary to the fentanyl patch she received but again could have occurred in the absence of receiving this drug. There are no accurate records of Mrs Page's respiratory rate but significant potentially fatal respiratory depression was likely to have resulted could have resulted from the combination of diamorphine, midazolam and fentanyl.

Duty of care issues

6.17 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care, to monitor Mrs Page and to document the effects of drugs prescribed. In my opinion this duty of care was adequately met except during the last day of her life when the prescription of diamorphine and midazolam was poor practice and may have contributed to Mrs Wilkie's death.

Summary

6.18 Mrs Page 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 Dr Barton on the 3rd March. In my view this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page 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.

Opinion on clinical management at Gosport War Memorial Hospital based on review of five cases presented by Hampshire Police

7.1 My opinion on the five cases I have been asked to review at Gosport War Memorial Hospital must be considered in context. My understanding is that the five cases have been selected by Hampshire Police because of concerns expressed relating to the management of these patients. Therefore my comments should not be interpreted as an opinion on the quality of care in general at Gosport War Memorial Hospital or of the general quality of care by the clinicians involved. My comments also relate to a period 2-4 years ago and the current clinical practice at the hospital may be very different today. An opinion on the quality of care in general at the hospital or of the clinicians would require a systematic review of cases, selected at random or with pre-defined patient characteristics. Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners.

7.2 However having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the General Medical Council or United Kingdom Central Council for Nursery, Midwifery and Health Visiting.

7.3 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 older 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 obstruction or where the patient does not wish to take regular medication (Appendix 2). In only one case were these criteria clearly fulfilled i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive doses 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 may have been routinely written up for many older frail patients admitted to Daedalus 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 Dr Lord's medical notes and her statement leads me to conclude 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 Dr Barton, were not adequate at the time these patients were admitted.

7.7 Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and Health Visiting, in relation to the professional competence of the medical and nursing staff, and the Commission for Health Improvement, in relation to the quality of service provided to older people in the Trust.

APPENDIX 1

Pharmacology of Opiate and Sedative Drugs

Morphine

8.1 Morphine is a potent opiate analgesic considered by many to the 'drug of choice' for the control of acute pain (Therapeutic Drugs Dollery). Recommended starting dosage regimens for a fit adult of 70Kg are for intravenous bolus dosing 2.5mg every 5 min until analgesia achieved with monitoring of the duration of pain and dosing interval, or a loading dose of 5-15mg over 30min than 2,5mg – 5mg every hour. A standard reference text recommends 'morphine doses should be reduced in elderly patients and titrated to provide optimal pain relief with minimal side effects'. Morphine can be used for sedation where sedation and pain relief are indicated, Dollery comments '*it should be noted that morphine is not indicated as a sedative drug for long-term use. Rather the use of morphine is indicated where the requirement for pain relief and sedation coexist such as in patients admitted to intensive care units and other high dependency areas, the morphine dose should be titrated to provide pain relief and an appropriate level of sedation. Frequently other pharmacological agents (e.g.: benzodiazepines) are added to this regimen to increase the level of sedation".*

8.2 Diamorphine

8.3

8.4 **Fentanyl**

8.5 Fentanyl is a transdermal opioid analgesic available as a transdermal patch. The '25' patch releases 25microg/hr.

8.6 The British National Formulary (copy of prescribing in palliative care attached Appendix 2) comments on the use of syringe drivers in prescribing in palliative care that drugs can usually be administered by mouth to control symptoms, and that indications for the parenteral route are: patient unable to take medicines by mouth, where there is malignant bowel obstruction, and where the patient does not wish to take regular medication by mouth, It comments that staff using syringe drivers should be adequately trained and that incorrect use of syringe drivers is a common cause of drug errors.

Heminevrin

Midazolam

8.1 Midazolam is a benzodiazepine sedative drug. It is used as a hypnotic, preoperative medication, sedation for procedures such as dentistry and GO endoscopy, long-term sedation and induction of general anaesthesia. lot is not licensed for subcutaneous use, but is described in the British National Formulary prescribing in palliative care section as 'suitable for a very restless patient: it is given in a subcutaneous infusion dose of 20-100mg/24 hrs.

8.2 DA standard text describes the use of sedation with midazolam in the intensive care unit setting, and states, "*sedation is most commonly met by a combination of a benzodiazepine and an opioid, and midazolam has generally replaced diazepam in this respect".* It goes on to state, "in critically ill patients, prolonged sedation may follow the use of midazolam infusions as a result of delayed administration". Potentially life threatening adverse effects are described, "Midazolam can cause dose-related CNS depression, respiratory and

cardiovascular depression. There is a wide variation in susceptibility to its effects, the elderly being particularly sensitive. Respiratory depression, respiratory arrest, hypotension and even death have been reported following its use usually during conscious sedation. The elderly are listed as a high-risk group; the elderly are particularly sensitive to midazolam. The dose should be reduced and the drug given slowly intravenously in a diluted form until the desired response is achieved. In drug interactions the following is stated. "*midazolam will also potentiate the central depressant effects of opioids, barbituates, and other sedatives and anaesthetics, and profound and prolonged respiratory depression might result.*

8.3

Hyoscine

8.4 The British National Formulary describes hyoscine hydrobromide as an antagonist (blocking drug) of acetylcholine. It reduces salivary and respiratory secretions and provides a degree of amnesia, sedation and antiemesis (antinausea). IN some patients, especially the elderly, hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness). The palliative care section describes it as being given in a subcutaneous infusion dose of 0.6-2.4mg/24 hours.

8.5

Use of syringe drivers

8.1 The BNF states 'oral medication is usually satisfactory unless there is severe nausea and vomiting, dysphagia, weakness, or coma in which case parenteral medication may be necessary. In the pain section it comments the non-opioid analgesics aspirin or paracetamol given regularly will often make the use of opioids unnecessary. An opioid such as codeine or dextropropoxyphene alone or in combination with a non-opioid analgesic at adequate dosage may be helpful in the control of moderate pain id non-opioids are not sufficient. If these preparations are not controlling the pain, morphine is the most useful opioid analgesic. Alternatives to morphine are hydromoprhine, oxycodone and transdermal fentanyl. In prescribing morphine it states 'morphine is given as an oral solution or as standard tablets every 4 hour, the initial dose depending largely on the patient's previous treatment. A dose of 5-10mg is enough to replace a weaker analgesic. If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50% the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and the use of adjuvant analgesics (such as NSAIDs) should also be considered. Although morphine in a dose of 5-10mg is usually adequate there should be no hesitation in increasing it stepwise according to response to 100mg or occasionally up to 500mg or higher if necessary. The BNF comments on the parenteral route '*diamorphine is preferred for injection. The equivalent intramuscular or subcutaneous dose of diamorphine is approximately a third of the oral dose of morphine*.'

8.2 In the chapter on pain relief in 'Drugs and the Older Person' Crome writes on the treatment of acute pain ' *treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patient and the presence of comorbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of*

prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

Prescribing for the Elderly
The British National Formulary states in Prescribing for the Elderly section "*The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and antiparkinsonian drugs, all of which must be used with caution*".

APPENDIX 2

BNF Prescribing in palliative care

Medical Report:
concerning the case of Gladys Mable Richards deceased

Prepared for:

Hampshire Constabulary
Major Crime Complex, Fratton Police Station, Kingston Crescent,
North End, Portsmouth, Hampshire PO2 8BU

by: Professor Brian Livesley MD FRCP
The University of London's Professor in the Care of the Elderly
Imperial College School of Science, Technology, & Medicine
The Chelsea and Westminster Hospital, London SW10 9NH

For the purpose of ... providing an independent view about treatment given to Mrs Gladys RICHARDS and the factor(s) associated with her death.

Synopsis

1. At the age of 91 years, Mrs Gladys RICHARDS was an in-patient in Daedalus ward at Gosport War Memorial Hospital.

1.1. A registered medical practitioner prescribed the drugs diamorphine, haloperidol, midazolam, and hyoscine for Mrs Gladys RICHARDS.

1.2. These drugs were to be administrated subcutaneously by a syringe driver over an undetermined number of days.

1.3. They were given continuously until Mrs RICHARDS became unconscious and died.

1.4. During this period there is no evidence that Mrs RICHARDS was given life sustaining fluids or food.

1.5. It is my opinion that as a result of being given these drugs, Mrs RICHARDS's death occurred earlier than it would have done from natural causes.

CONTENTS

page no.

1. The writer's declaration 3
2. Introduction 3
3. Information relating to Mrs Gladys RICHARDS (deceased) 3
4. Relevant aspects of Mrs RICHARDS's medical history 4
5. Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital 11
6. Death certification and cremation 14
7. Conclusions 14
8. My opinion 16
9. Appendix A – the documents I have received and read 18
10. Appendix B – facts of the environment obtained from the statements of Mrs RICHARDS's daughters 22
11. Appendix C – Glossary 28
12. Appendix D – Texts used for reference 30
13. Appendix E – My qualifications and experience 31
14. My signature and dating of this report 34

The writer's declaration

1. This report consisting of thirty-four pages is true to the best of my knowledge and belief and I make it knowing that if tendered in evidence, I shall be liable for prosecution if I have wilfully stated in it anything that I know to be false or do not believe to be true.

Introduction

2. The documents with which I have been provided and the visits I have made to the hospitals involved in this enquiry are listed in the Appendix A.

2.1. Appendix B contains facts of the environment provided by the statements of Mrs Gillian MACKENZIE (the elder daughter of Mrs Gladys RICHARDS (deceased)) and Mrs Lesley Frances LACK (the younger daughter).

2.2. I have indicated any medical terms in **bold type**. I have defined these terms in a glossary in Appendix C.

2.3. I have included in Appendix D references to published material.

2.4. Appendix E contains details of my qualifications and experience.

2.5. 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.

Information relating to Mrs Gladys Richards (deceased)

3. Mrs Gladys Mable RICHARDS (née Beech) was born on **Code A** and died on 21st August 1998 aged 91 years.

3.1. Mrs Richards has two daughters. They are Mrs Gillian MACKENZIE (the elder daughter) and Mrs Lesley Frances LACK.

3.1.1. Mrs Lack is a retired Registered General Nurse. She retired during 1996 after 41 years continuously in the nursing profession. For 25 years prior to her retirement she was involved in the care of elderly people. For 20 years prior to retirement she held supervisory and managerial positions in this particular field of nursing.

3.2. The Glen Heathers Nursing Home is a private registered nursing and residential home at Lee on the Solent, Hampshire. Dr J BASSETT is a general practitioner who visits.

3.3. The Royal Hospital Haslar is an acute general hospital in Gosport, Hampshire serviced by the Armed Forces at the time of the incident but available as a National Health Service facility to local people.

3.4. Gosport War Memorial Hospital is part of the Portsmouth Healthcare NHS Trust.

3.4.1. Daedalus ward is a continuing care and rehabilitation ward at Gosport War Memorial Hospital.

3.5. Dr Jane Ann BARTON is a registered medical practitioner who in 1988 took up a part-time post as clinical assistant in elderly medicine. This post became centered at Gosport War Memorial Hospital. She retired from this part-time post in the year 2000.

3.6. Mr Philip James BEED is the clinical manager and charge nurse on Daedalus ward at Gosport War Memorial Hospital. Ms Margaret COUCHMAN and Ms Christine JOICE are registered general nurses who were working on Daedalus ward at the time of the incident.

3.7. Dr Anthea Everista Geredith LORD is a consultant physician, within the department of elderly medicine of Portsmouth Healthcare NHS Trust, who was usually responsible for the patients on Daedalus ward and who was on study leave on 17/18 August 1998.

3.7.1. Other consultant physicians from the department of elderly medicine provide on-call consultant physician cover when Dr LORD is absent from duty.

Relevant aspects of Mrs RICHARDS's medical history

4. Mrs RICHARDS became resident at the Glen Heathers Nursing Home on 5th August 1994 at the age of 87 years and although disorientated and confused she was able to wash and dress herself and able to go up and down stairs and walk well.

4.1. It is noted that she also had a past medical history of bilateral deafness for which she required hearing aids.

4.1.1. Unfortunately both of her hearing aids were lost by December 1997 while she was at the Glen Heathers Nursing Home and had not been replaced by July 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital).

4.1.2. It is noted that on 8th July 1998 her general practitioner, Dr J BASSETT wrote to the audiologist at Queen Alexandra Hospital, Cosham requesting an '**URGENT** [sic]' domiciliary visit to Glen Heathers Nursing Home. This was '... with a view to supplying her [Mrs RICHARDS] with two new hearing aids.... Since her poor hearing probably contributes to her

confusional state I would be grateful if you would visit with a view to fitting of replacement aids as soon as possible please.'

4.2. It is also noted that Mrs RICHARDS had had operations for the removal of cataracts and required glasses.

4.2.1. Unfortunately her spectacles were also lost at the Glen Heathers Nursing Home and had not been replaced by August 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital.

4.2.2. As Dr BASSETT had noted Mrs RICHARDS poor hearing probably contributed to her confusional state. The absence of her spectacles would also make it difficult for Mrs RICHARDS to be aware of what was going on around her, further aggravate her confusional state due to lack of sensory stimulation, and increase her dependency on others for her normal daily activities.

4.2.3. The absence of both her hearing aids and her spectacles would make the assessment of and communication with Mrs RICHARDS extremely difficult.

4.2.3.1. It is noted that such sensory deprivation can produce and aggravate confusional and disorientated states.

4.3. At the beginning of 1998, she had become increasingly forgetful and less able physically but was inclined to wander and she had about a six months' history of falls.

4.4. On 29th July 1998, at the Glen Heathers Nursing Home, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.

4.4.1. In the Accident & Emergency department she was given 2.5mg of **morphine** and 50 mg of **cyclizine** at 2300 hours to relieve her pain and distress. She was known to be taking **haloperidol** 1mg twice daily and **Tradazone** 100mg at night.

4.5. On 30th July 1998 Mrs RICHARDS had a right cemented hemiarthroplasty [an artificial hip joint inserted].

4.5.1. Post-operatively she was given 2.5 mg morphine intravenously on July 30th at 0230 hours, 31st at 0150 and 1905 hours, and on August 1st at 1920 hours and 2nd at 0720 hours. From August 1st – 7th she was weaned over to two tablets of **co-codamol,** requiring these on average twice daily for pain relief.

4.5.2. On 3rd August 1998 it was noted 'All well. Sitting out early mobilization'.

4.6. On 5th August 1998, Dr REID, a consultant geriatrician, saw her. He stated in a letter that '... she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport Memorial Hospital.'

4.6.1. Dr REID also noted that Mrs RICHARDS had continued on Haloperidol and '... her Trazodone has been omitted. According to her daughters it would seem that since her Tradozone has been omitted she has been much brighter mentally and has been speaking to them at times.'

4.7. A discharge letter, dated 10th August 1998, was sent by the sergeant staff nurse at the Royal Hospital Haslar and addressed to 'The Sister in Charge Ward [sic] Memorial Hospital, Bury Road, Gosport, Hants.' It contained the following information:-

4.7.1. After the operation Mrs RICHARDS became '...fully weight bearing, walking with the aid of two nurses and a **Zimmer frame**.' She was noted to require 'total care with washing and dressing, eating and drinking....' She was '... continent, when she become[s] fidgety and agitated it means she wants the toilet....' She 'Occasionally says recognisable words, but not very often.' Her wound 'Is healed, clean and and dry.'

4.8. On 11th August 1998, Mrs RICHARDS was transferred to Daedalus ward at the Gosport War Memorial Hospital. She was not in pain and had been fully weight bearing at the Royal Hospital Haslar walking with the aid of two nurses and a Zimmer frame.

4.8.1. At the Gosport War Memorial Hospital there was an unsigned 'Summary' record which is apparently a Nursing record and this states:-

4.8.1.1. '11-8-98 Addmitted [sic] from E6 Ward Royal Hospital Haslar, into a continuing care bed. Gladys had sustained a right fractured neck of Femur on 30th July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a Zimmer frame. Daughter visits regularly and feeds mother. She wishes to be informed Day or night of any deterioration in mothers condition....'

4.8.2. The contiguous 'Assessment Sheet' states, 'Patient has no apparent understanding of her circumstances due to her impaired mental condition ... Deaf in both ears ... Cataract operation to both eyes ... occasionally says recognisable words, but not very often ... soft diet. Enjoys a cup of tea ... requires feeding ... Dental/Oral status Full "Set" – keeps teeth in at night.'

4.8.3. The 'Patient Medication Information' states, '11.8.98 ... Haloperidol O[rally] 1 mcg [looks like 'mcg' but probably is 'mg' since this drug is not prescribed in single **microgram** doses] B.D. [twice daily]'

4.9. ??[initials]B [subsequently identified as Dr BARTON] has written in the medical case records '11-8-98 Transferred to Daedalus Ward Continuing Care.... O/E [on examination] Impression frail demented lady [paragraph] not obviously in pain [paragraph] Please make comfortable [paragraph] transfers with hoist Usually continent needs help with **ADL [activities of daily living]**.... I am happy for nursing staff to confirm death.'

4.10. At 1300 hours on the 13th August 1998 the Nursing Contact Record states 'Found on floor at 13.30hrs [sic]. Checked for injury none apparent at time hoisted into safer chair 20.00 [hours][altered on record to 19.30] pain Rt [right] hip internally rotated. Dr BRIGG contacted advised Xray AM [in the morning] & **analgesia** during the night. Inappropriate to transfer for Xray this PM [evening] [initialled signature (? by whom)] RGN [Registered General Nurse] [next line] Daughter informed.'

4.11. Dr BARTON has recorded '14-8-98 Sedation/pain relief has been a problem screaming not controlled by haloperidol 1 [illegible symbol or word] but very sensitive to **oramorph**. Fell out of chair last night ... Is this lady well enough for another surgical procedure?'

4.12. In her contiguous note Dr BARTON has recorded '14-8-98 Dear [?] Cdr [Commander] SPALDING Further to our telephone conversation thank you for taking this unfortunate lady who slipped from her chair at 1.30 pm yesterday and appears to have dislocated her R[ight] hip.... She has had 2.5ml of 10mg/5ml Oramorph at midday.'

4.12.1. According to the letter signed by Philip BEED, Mrs RICHARDS was given 10mgs of Oramorph at 1150 hours on 14th August 1998 prior to being transferred back to the Royal Hospital Haslar.

4.13. The Nursing Contact Record at Daedalus ward continues:-

4.13.1. '14/8/98 am [morning] R[ight] Hip Xrayed – Dislocated [paragraph] Daughter seen by Dr BARTON & informed of situation. For transfer to Haslar A&E [accident and emergency department] for reduction under sedation [initialled signature]'

4.13.2. 'pm [afternoon or evening of 14th August 1998] Notified that dislocation has been reduced. [Mrs RICHARDS] To stay in Haslar [hospital] for 48 hours then return to us [[initialled signature] Family aware.'

4.14. At the Royal Hospital Haslar (at 1400 hours) Xray having confirmed that the hemiarthroplasty had dislocated, intravenous sedation using 2 mgs of midazolam

allowed the dislocation to be corrected by traction. The procedure was described as 'Under sedation c [with] CVS/RS [cardiovascular and respiratory systems] monitoring. ... Easy reduction.' Mrs RICHARDS was noted to be 'rather unresponsive following the sedation. The [She] gradually became more responsive....' She was then admitted the Royal Hospital for 48 hours observation.

4.15. Apart from two tablets of co-codamol on the 15th August 1998, she did not need to be given any pain relief following the reduction of her hip dislocation.

4.15.1. Two days later, on 17th August 1998, it was recorded that 'She was fit for discharge that day and she was to remain in straight knee splint for four weeks. In the discharge letter from Haslar Hospital it was also recorded that Mrs RICHARDS was to return to Daedalus Ward. It was further stated that 'She has been given a canvas immobilising splint to discourage any further dislocation, and this must stay in situ for four weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing.'

4.16. On 17th August 1998 it was also recorded that she was 'Fit for discharge today (Gos[port] War Mem[orial hospital). To remain in straight knee splint for 4/52 [four weeks] ... No follow-up unless complications.'

4.17. She was returned to Daedalus ward in the Gosport War Memorial Hospital later that day but in a very distressed state. The Daedalus ward nursing record states 'Returned from R.N. Haslar, patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew To remain in straight knee splint for 4/52 [four weeks] For pillow between legs at night (abduction) No follow-up unless complications.'

4.17.1. Mrs RICHARDS was given Oramorph 2.5 mg in 5mls. The nursing record for 17th August 1998 further states '1305 [hours] ... Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an Xray. M. COUCHMAN. [paragraph] pm Hip Xrayed at 1545 [hours] Films seen by Dr PETERS & radiologist & no dislocation seen. For pain control overnight & review by Dr BARTON mane [in the morning]. ?[illegible nurse signature]

4.17.1.1. This radiograph was reported by Dr. DOMJAN, Consultant Radiologist as showing 'RIGHT HIP: The right hemiarthroplasty is relocated in the **acetabulum**.'

4.18. On 17th August 1998, Dr BARTON noted 'Readmission to Daedalus from RHH [Royal Hospital Haslar] Closed reduction under iv [intravenous] sedation remained unresponsive for some hours now appears peaceful. Plan Continue haloperidol [paragraph] Only give oramorph if in severe pain See daughter again.'

4.19. On 18th August 1998, Dr BARTON recorded 'Still in great pain [paragraph] Nursing a problem. [paragraph] I suggest sc[subcutaneous] diamorphine/Haloperidol/midazolam [paragraph] I will see daughters today [paragraph] please make comfortable.'

4.20. The nursing Contact Record on Daedalus ward in the Gosport War Memorial Hospital continues:-

4.20.1. '18/8/98 am Reviewed by Dr Barton. For pain control via syringe driver. [paragraph] 1115 Treatment discussed with both daughters [Mrs LACK and Mrs MACKENZIE]. They agree to use of **syringe driver** to control pain [It is noted that Mrs LACK has disagreed with this statement] & allow nursing care to be given. [paragraph] 1145 Syringe driver diamorphine 40 mg. Haloperidol 5 mg, Medazolam [midazolam] 20 mg commenced'

4.20.2. '18/8/98 20.00 Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs. [paragraph] Daughter quite upset and angry about mother's condition, but appears happy that she is pain free at present. C JOICE.'

4.20.2.1. It is noted that a 'disturbance reaction' occurs in patients when they are moved that is easily mistaken for pain requiring specific treatment. It is noted here that Mrs RICHARDS was described as being 'pain free' at this time apart from when she was being moved.

4.20.3. The nursing Contact Record continues 'Daughter, Jill, stayed the night with Gladys [Mrs RICHARDS], grandson arrived in early hours of morning [initialled signature; dated '19/8/98'] [paragraph] He would like to discuss Grand mother's condition with someone – either Dr. Barton or Phillip Beed later today [initialled signature]' [paragraph] '19/8/98 am Mrs Richards comfortable. [paragraph] Daughters seen. Unhappy with various aspects of care, complain[t] to be handled officially by Mrs S Hutchings Nursing co-ordinator [initialled signature]'

4.20.4. It is noted that there is no continuing nursing Contact Record for the 20th August 1998.

4.20.5. The contiguous nursing Contact Record states '21/8/98 12.13 [hours] Patient's [Mrs RICHARDS] overall condition deteriorating, medication keeping her comfortable. Daughters visited during the morning. C JOICE'

4.21. Dr BARTON's next contiguous medical record was on 21st August 1998 when she wrote 'Much more peaceful [paragraph] needs Hyoscine for rattly chest'.

4.21.1. It is noted that Mrs RICHARDS was already being given hyoscine at this time and had been doing so continuously since 19th August 1998.

4.21.2. Nurse GRIFFIN made the next note in the medical records on 21st August 1998 stating that Mrs Richards was dead at 2120 hours.

4.22. The Nursing Care Plan records state:-

4.22.1. '12.8.98 Requires assistance to settle and sleep at night.... 12.8.98 Haloperidol given at 2330 [hours] as woke from sleep very agitated shaking and crying. Didn't settle for more than a few minutes at a time. Did not seem to be in pain.'

4.22.2. '13.8.98 oromorph at 2100 [hours] Slept well [initialled signature] [paragraph] For Xray tomorrow morning [initialled signature]'

4.22.3. '14.8.98 Same pain in rt[right] leg / ?[query] hip this am. [initialled signature]'

4.22.4. 'Re-admitted 17/8/98'

4.22.5. '17.8.98 Oromorph [Oramorph] 10mg/5ml at present.'

4.22.6. '18.8.98 Now has a syringe driver with 40mgs Diamorphine – comfortable. Daughters stayed. [initialled signature]'

4.22.7. 'Daughters stayed with Gladys [Mrs RICHARDS] overnight. [initialled signature]'

4.22.8. There is no record of continuance of the Nursing Care Plan for 20th and 21st August 1998.

4.22.9. After Mrs RICHARDS had been readmitted to Daedalus ward on 17th August 1998, there is no record between 17th and 21st August 1998 in the patient Nursing Care Plan for 'Nutrition'. On 21st August the record states 'no food taken [initialled signature]'.

4.22.9.1. There is no record that Mrs RICHARDS was offered any fluids.

4.22.10. Similarly, the Nursing Care Plan for 'Constipation' shows no record between 17th and 21st August1998. On 21st August the record states 'BNO [bowels not open] [initialled signature]'

4.22.11. The Nursing Care Plan for 'Personal Hygiene' states:-

4.22.11.1. '18.8.98 Complete Bed Bath given plus oral [Signature] Hygiene [second signature]'

4.22.11.2. '18.8.98 Night: oral care given frequently'

4.22.11.3. '19.8.98 Nightie changed & washed, repositioned. Apparently pain free during care [initialled signature]'

4.22.11.4. It is noted that there is no record of Mrs Richards being attended to for 'Personal Hygiene' on 20th August 1998.

4.22.11.5. '21.9.98 General care and oral hygiene given [initialled signature]'

4.23. The drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital from the time of her admission there on 11th August 1998 are described below.

Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital

5. Dr BARTON wrote the following drug prescriptions for Mrs RICHARDS.

5.1. On 11th August 1998:-

5.1.1. Oramorph 10mgs in 5mls to be given orally four hourly. On the Administration Record these doses are recorded as being given—

5.1.1.1. twice on 11th August 1998 (10mg at 1015 [?1215] and 10mg at 1145 [?pm]);

5.1.1.2. once on 12th August (10mg at 0615);

5.1.1.3. once on 13th August (10mg at 2050);

5.1.1.4. once on 14th August (5ml [10mg] at 1150);

5.1.1.5. four times on 17th August (2.5ml [5mg] at 1300, 2.5ml [5mg] at ????[time illegible], 2.5ml [5mg] at1645, and 5ml [10mg] at 2030); and,

5.1.1.6. twice on 18th August 1998 5ml [10mg] at 01230[sic and ? meaning 0030 hours] and 5ml [10mg] at [?]0415).

5.1.2. Diamorphine at a dose range of 20 – 200 mg to be given subcutaneously in 24 hours.

GMC100829-0196

5.1.2.1. None of this diamorphine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.3. Hyoscine at a dose range of 200 – 800 mcg [micrograms] to be given subcutaneously in 24 hours.

5.1.3.1. None of this hyoscine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.4. Midazolam at a dose range of 20-80 mgs to be given subcutaneously in 24 hours.

5.1.4.1. None of this midazolam prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.5. Haloperidol 1mg orally twice daily. It is noted that at the top of this prescription chart 'TAKES MEDICINE OFF A SPOON' [sic] is clearly written.

5.1.5.1. She was give 1mg of haloperidol at 1800 hours on 11th August 1998, at 0800 and 2330 hours on 12th August 1998, at 0800 and 1800 hours on 13th August 1998.

5.1.5.2. In addition, on 13th August 1998, Mrs RICHARDS was prescribed haloperidol 2mgs in 1ml to be administered orally as required at a dose of 2.5ml [this figure has been altered and also can be read as 0.5 ml] to be given 'IF NOISY' [sic]. She was given a dose [quantity not stated bearing in mind the altered prescription] at 1300 on 13th August 1998.

5.1.5.3. She was also given 1mg of haloperidol at 0800 hours on 14th and also at 1800 hours on 17 August 1998.

5.1.6. It is noted that, apart from 2330 hours on 12 August 1998, at the above times when Mrs RICHARDS was given haloperidol she was also give 10ml of **Lactulose** [a purgative].

5.2. On 12th August 1998:-

5.2.1. Oramorph 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly [equivalent to 5mgs of oramorph].

5.2.1.1. Although this drug was apparently not administered its prescription was written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

5.2.2. Oramorph 10mgs in 5mls to be given orally once at night.

5.2.2.1. Although this drug was apparently not administered its prescription was also written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

5.3. 18th August 1998:-

5.3.1. Diamorphine at a dose range of 40-200mg to be administered subcutaneously in 24 hours

5.3.2. Haloperidol a dose range of 5-10 mgs to be administered subcutaneously in 24 hours.

5.4. On 18th, 19th, 20th, and 21st August 1998, Mrs RICHARDS was given simultaneously and continuously subcutaneously diamorphine 40mgs, and haloperidol 5mgs, and midazolam 20mgs during each 24 hours.

5.4.1. These drugs are recorded as being administered at the same time of day on each of the four days they were given. They were administered at 1145, 1120, 1045, and 1155 for 18th, 19th, 20th, and 21st August 1998 respectively.

5.4.1.1. All these drugs were administered at the times stated and were signed off by initials as being co-administered by the same person each day. Over the four days of 18th, 19th, 20th, and 21st August 1998, at least three nurses were involved in administering these drugs.

5.4.1.2. According to the prescription charts these drugs were signed for as being administered to Mrs RICHARDS via the syringe driver by Mr Philip BEED on 18th and 19th August 1998, by Ms Margaret COUCHMAN on 20th August 1998, and by Ms Christine JOICE on 21st August 1998.

5.4.2. It is noted that on the 19th, 20th, and 21st August 1998 the drugs midazolam 20mgs, diamorphine 40mgs, and haloperidol 5mgs were also co-administered subcutaneously in 24 hours with 400mcg of hyoscine [this last drug had been

prescribed by Dr BARTON to be given as required on 11th August 1998 but its administration was not commenced until 19th August 1998].

5.4.3. It is also noted that all the drugs for subcutaneous administration were not prescribed at specific starting dosages but each was prescribed for a wide range of dosages and for continuous administration over 24-hour periods.

5.4.3.1. It is not known who selected the dosages to be given.

Death certification and cremation

6. The circumstances of Mrs RICHARDS death have been recorded as follows:

6.1. In a document [Case no. 1630/98] initialled by the Coroner on 24th August 1998 'Reported by Dr BARTON [sic]. Deceased had undergone surgery for a fractured neck of femur. Repaired. Death cert[ificate] issued. [paragraph] THOMAS [sic]

6.2. The cause of death was accepted by the Coroner on 24th August 1998 as being due to:-

6.2.1. '1(a) Bronchopneumonia'.

6.2.2. The death was certified as such by Dr J A BARTON and registered on 24th August 1998.

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

6.3. The body was cremated.

Conclusions

7. Mrs Gladys Mable RICHARDS died on 21st August 1998 while receiving treatment on Daedalus ward at Gosport War Memorial Hospital.

7.1. Some fours years earlier, on 5th August 1994, Mrs RICHARDS had become resident at the Glen Heathers Nursing Home.

7.2. Mrs RICHARDS's 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.

7.3. On 29th July 1998, Mrs RICHARDS 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.

7.4. Despite her confused state, Mrs RICHARDS was considered by medical staff at the Royal Hospital Haslar to be suitable for implantation of an artificial hip joint. This took place on 30th July 1998.

7.5. 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.

7.6. At that time Dr BARTON recorded that Mrs RICHARDS was not obviously in pain but despite this Dr BARTON prescribed Oramorph [an oral morphine preparation] to be administered orally four hourly.

7.6.1. At that time also Dr BARTON prescribed for Mrs RICHARDS diamorphine, hyoscine, and midazolam. These drugs were to be given subcutaneously and continuously over periods of 24 hours for an undetermined number of days and the exact dosages were to be selected from wide dose ranges.

7.6.2. Also on 11th August 1998, at the end of a short case note, Dr BARTON wrote 'I am happy for nursing staff to confirm death'.

7.6.3. 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 midazolam) were not administered at that time.

7.7. On 13th August 1998, Mrs RICHARDS's artificial hip joint became dislocated.

7.8. The following day, 14th August 1998, although Dr BARTON had recorded 'Is this lady well enough for another surgical procedure?' she arranged for Mrs RICHARDS to be transferred back to Haslar Hospital where the dislocation of the hip was reduced.

7.8.1. It is noted that at the age of 91 years, and despite Dr Barton's comment about Mrs RICHARDS, and her confused mental state, Mrs RICHARDS was considered well enough by the staff at the Royal Hospital Haslar to have two operations on her right hip within about two weeks.

7.9. Three days later, on 17th August 1998, Mrs RICHARDS was returned to the Gosport War Memorial Hospital on a sheet and not on a stretcher. She was very distressed when she reached Daedalus ward.

7.10. There is no evidence that Mrs RICHARDS, 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.

7.11. Despite this, and on 18th August 1998, Dr BARTON, while knowing of Mrs RICHARDS's sensitivity to oral morphine and midazolam, prescribed diamorphine, midazolam, haloperidol, and hyoscine to be given (from wide dosages ranges) continuously subcutaneously and by a syringe driver over periods of 24 hours for an unlimited period.

7.11.1. Neither midazolam nor haloperidol is licensed for subcutaneous administration.

7.11.2. 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.

7.11.3. It is also noted that Mrs RICHARDS was not receiving treatment for cancer.

7.12. There is no evidence that in fulfilling her duty of care Dr BARTON reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.

7.13. During this period when a syringe driver was being used to administer the subcutaneous drugs, there is no evidence that Mrs RICHARDS was given fluids or food in any appropriate manner.

7.14. There is no evidence that in fulfilling their duty of care Mr Philip BEED, Ms Margaret COUCHMAN and Ms Christine JOICE reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment they were administering was indicated.

7.15. There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification and during every 24 hours from 18th August 1998 until Mrs RICHARDS died on 21st August 1998.

7.16. Dr Barton recorded that death was due to bronchopneumonia.

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

My opinion

8. When Mrs RICHARDS was first admitted to Daedalus ward at Gosport War Memorial hospital on 11th August 1998 she was not in pain and had been fully weight bearing walking with the aid of two nurses and a Zimmer frame.

8.1. Despite recording that Mrs RICHARDS was not in pain, on 11th August 1998 Dr BARTON prescribed wide dosage ranges of opiate and sedative drugs to which Mrs RICHARDS was known to be sensitive.

8.1.1. Dr Barton also recorded that 'I am happy for nursing staff to confirm death.' when Mrs RICHARDS had been admitted for rehabilitation and her death was not obviously imminent.

8.2. When, at the age of 91 years, Mrs RICHARDS dislocated her operated hip and despite her confused mental state, she was considered well enough to have a second operation on her right hip within about two weeks of the first operation.

8.3. There is no evidence to show that after her second operation Mrs RICHARDS, 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.

8.4. It is my opinion, and there is evidence to show, that Mrs RICHARDS was capable of receiving oral medication for the relief of the pain she was experiencing on 17th August 1998.

8.5. Mrs RICHARDS was known by Dr BARTON to be very sensitive to Oramorph, an oral morphine preparation, and to have had a prolonged sedated response to intravenous midazolam.

8.6. Despite this, and from 18th August 1998 for an undetermined and unlimited number of days, Dr BARTON prescription led over 24-hours periods to the continuous subcutaneous administration to Mrs RICHARDS of diamorphine 40mgs, haloperidol 5mgs, and midazolam 20mgs to which was added hyoscine 400mcg from 19th August 1998.

8.7. The administration of these drugs continued on a 24-hours regime without their dosages being modified according to Mrs RICHARDS's response to them and until Mrs RICHARDS died on 21st August 1998.

8.8. There is no record that Mrs RICHARDS was given any food or fluids to sustain her from the 18th August 1998 until she died on 21st August 1998.

8.9. As a result of the continuous subcutaneous administration of the prescribed drugs diamorphine, haloperidol, midazolam, and hyoscine Mrs RICHARDS became unconsciousness and died on 21st August 1998.

8.10. No other event occurred to break the chain of causation and in my opinion Mrs RICHARDS's death was directly attributable to the administration of the drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998.

8.11. It is my opinion that Mrs Gladys RICHARDS's death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine, haloperidol, midazolam, and hyoscine which had been prescribed to be administered continuously by a syringe driver for an undetermined number of days.

APPENDIX A

14. I have received and read the following documents:-

14.1. The letter of DCI BURT dated 22nd November 1999 that gave an initial overview of the case.

14.2. The documents in the file DCI BURT presented at our meeting on 28th January 2000 as follows:-

14.2.1. 1) Draft (unsigned) statement (MG11) of Lesley HUMPHREY.
14.2.2. 2) Copy of PEC (NHS) T Health Record (LH/1/C).
14.2.3. 3) Copy of RHH Medical Record (AF/1/C).
14.2.4. 4) Draft (unsigned) statement (MG11) of Gillian MACKENZIE.
14.2.5. 5) Draft (unsigned) statement of Lesley LACK.

14.3. The documents in the file DCI BURT presented at our meeting on 8th March 2000 including those pursuant to my request of 28th January 2000 (documents WX1, WX2, and YZ were forward to me on 9 March 2000) as follows:-

14.3.1. A Typed copy of Notes prepared by Mrs LACK and given to Portsmouth Healthcare NHS Trust
14.3.2. B Typed copy of additional page of notes which was prepared by Mrs LACK but, apparently, not passed to Portsmouth Healthcare NHS Trust
14.3.3. C Typed copy of Notes prepared by Mrs LACK and given to Social Services
14.3.4. D Typed copy of comments made by Mrs LACK in respect of letter from Portsmouth Healthcare NHS Trust which represented a response to her Notes of complaint (A)

14.3.5.	E	Typed copy of comments made by Mrs LACK in respect of a Report prepared by Portsmouth Healthcare NHS Trust which resulted in the letter referred to above
14.3.6.	F	As D above but made by Mrs MACKENZIE
14.3.7.	G	As E above but made by Mrs MACKENZIE
14.3.8.	HI	Copy of letter written by Mrs MACKENZIE to DI MORGAN (OIC of initial investigation) plus 5 copies newspaper cuttings
14.3.9.	JK	Copy of Coroner's Officer's Form
14.3.10.	L	Copy of letter from Dr REID to S/Cdr SCOTT
14.3.11.	M	Copy of Report made by Dr LORD during original investigation
14.3.12.	N	Copy of additional newspaper cutting
14.3.13.	O (1)	Typed copy of signed statement of Anne FUNNELL (RHH)
14.3.14.	O (2)	Typed copy of signed statement of Lesley HUMPHREY (Portsmouth Healthcare NHS Trust)
14.3.15.	O (3)	Copy of signed statement of Lesley LACK
14.3.16.	O (4)	Copy of final draft of Gillian MACKENZIE's statement
14.3.17.	PQ	Copy of schedule of x-ray images (RHH)
14.3.18.	R	Copy of Risk Event Record (Portsmouth Healthcare NHS Trust)
14.3.19.	S (1)	Copy of letter which DCI BURT has sent to Lesley HUMPHREY (Portsmouth Healthcare NHS Trust) raising various issues
14.3.20.	S (2)	Copy of entries in medical directories 1998/1999 - Dr Jane Ann BARTON
14.3.21.	S (3)	Copy of letter from Mrs MACKENZIE to DCI BURT
14.3.22.	S (4)	Copy of documents which accompanied the two Portsmouth Healthcare NHS Trust x-ray images
14.3.23.	T	Copy of various documents which featured in a Social Services Case Conference stemming from receipt of Mrs LACK's Notes of complaint (C above)
14.3.24.	UV	Copy of Death Certificate - Mrs RICHARDS
14.3.25.	WX1	Witness Statement of Mrs Gillian MACKENZIE dated March 6 2000
14.3.26.	WX2	Copy of letter from DR J.H. BASSETT to Mrs MACKENZIE with an addendum of five pages being a photocopy from 'Toxic Psychiatry' a book by Dr Peter BREGGEN published by Harper Collins.
14.3.27.	YZ	Two extracts from 'Criminal Law. Diana Rowe. Hodder & Stoughton 1999.'

14.4. On 8th March 2000, in the presence of DCI BURT, I visited:-

14.4.1. the Gosport Memorial Hospital and followed the passageways along which Mrs Richards was conveyed and the ward areas in which she was treated; and,

14.4.2. the Royal Hospital Haslar and followed the passageways along which Mrs Richards was conveyed and the ward area in which she was treated.

14.4.2.1. At the Royal Hospital Haslar, on 8th March 2000, in the presence of DCI BURT, I was also shown twelve (12) radiographs relating to Mrs Richards' treatment there on 12th April 1998, 17th July 1998, 14th August 1998, 29th July 1998, and 31st July 1998.

14.5. In addition I have read the following the documents given to me by DCI BURT on 12th May 2000 consisting of the following which are numbered below as listed in the two containing ring binders:

14.5.1. E 25 Copy of Glen Care Homes file Re: Gladys RICHARDS supplied by Glen Care Homes
14.5.2. E 22 Copy of Hampshire County Council Social Services file Re: Gladys RICHARDS
14.5.3. E23 Copy of Glen Care Homes file Re: Gladys RICHARDS supplied Nursing Homes Inspectorate
14.5.4. E 24 Copy Portsmouth and South East Hampshire Health Authority GP Patient Records of Gladys RICHARDS
14.5.5. D 63 Police letter 090300 to Miss CROSS, Haslar Hospital with further questions
14.5.6. D 65 Letter 100400 from Miss CROSS at Haslar including Patient transfer order and further medical records
14.5.7. D 104 Letter 080200 from Mrs. MACKENZIE with notes Re: draft statement
14.5.8. D 108 Portsmouth NHS Trust Dept. of Diagnostic Imaging report folder
14.5.9. D 110 Copy typed Gladys RICHARDS Death Certificate dated 240898

14.6. I have also read the documents given to me by DCI BURT on 19th July 2000, consisting of copies of the statements made by:-

14.6.1. JOICE Christine
14.6.2. GIFFIN Sylvia Roberta
14.6.3. PULFORD Monica Catherine
14.6.4. WALKER Fiona Lorraine
14.6.5. MARJORAM Catherine
14.6.6. BALDACCHINO Linda Mary
14.6.7. PERKINS Margaret Joan
14.6.8. TUBBRITT Anita
14.6.9. COUCHMAN Margaret
14.6.10. WALLINGTON Kathleen Mary
14.6.11. FLETCHER Anne
14.6.12. COOK Joanne
14.6.13. MOSS JEAN Kathleen
14.6.14. TYLER Christina Ann

14.7. I have also read statements, provided on 30th August 2000 by DCI BURT, made by:

14.7.1. Doctor Jane Ann BARTON
14.7.2. Phillip James BEED

14.8. I have also received from DCI BURT on 8th September 2000 and read copies of:-

14.8.1. A letter dated 18th August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.8.1.1. Enclosed with this letter was a copy of a letter dated 9th August 2000 from Ms Jill BAKER to Mrs Gillian MACKENZIE to which had been added a petition form.

14.9. A letter dated 21st August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.9.1. Enclosed with this letter was a copy of a letter dated 14th December 1998 from Ms Lesley HUMPHREY, Quality Manager at Portsmouth Healthcare NHS Trust Central Office to Mrs Gillian MACKENZIE. This had enclosed with it a copy of a letter dated 22nd September 1998 from Mr Max MILLETT, Chief Executive of Portsmouth Healthcare NHS Trust.

14.10. Copies of Witness Statements (taken by Mrs S HUTCHINGS who led the initial Internal Inquiry as Investigating Officer of Portsmouth Healthcare NHS Trust) as follows:-

14.10.1. On 3rd September 1998 statement consisting of four pages from Mrs Jenny BREWER – Staff Nurse Daedalus Ward to which is attached an additional statement (three pages) by Staff Nurse Brewer (the first page of this three pages is headed Portsmouth Healthcare NHS Trust and has been signed on page three by S. N J Brewer RGN and dated 9-9-98 (Reference D142)).

14.10.2. On 8th September 1998 statement consisting of five pages from Mr Philip BEED – Clinical Manager Daedalus Ward (Reference D143).

14.10.3. On 9th September 1998 statement consisting of three pages from Ms Christine JOICE – Staff Nurse Daedalus Ward (Reference D144).

14.10.4. On 8th September 1998 statement consisting of two pages from Ms Monica PULFORD – Enrolled Nurse Daedalus Ward (Reference D145).

14.10.5. On 3rd September 1998 statement consisting of four pages from Ms Margaret COUCHMAN – Staff Nurse Daedalus Ward (Reference D146).

14.11. A copy of the National Council for Hospice and Specialist Palliative Care Services paper entitled 'Ethical decision-making in palliative care'.

14.12. On 5th and 6th October 2000 I received from Hampshire Constabulary and subsequently read:-

14.12.1. The records of the interviews conducted with Dr Anthea Everista Geredith LORD on 27th September 2000.

14.12.2. During these interviews Dr LORD produced as listed in the Officer's Report by DC McNally the following documents:-

14.12.2.1. Drug Therapy Guidelines for subcutaneous fluid replacement as approved by the Elderly Medicine and Formulary & Medicines Group of Portsmouth Hospitals and Portsmouth Healthcare updated for 1998.

14.12.2.2. Consultants' Rota for August 1998 of the Department of Medicine for Elderly People (Ref: CI/28.7.98).

14.12.2.3. Memorandum from Mrs. L HUMPHREY of Portsmouth Health Care NHS Trust to Dr. LORD dated 17th December 1998 and headed 'Mrs. Richards deceased, Gosport War Memorial Hospital, 21st August, 1998.'

14.12.2.4. Letter from Dr R I REID, Medical Director of Portsmouth Health Care NHS Trust giving approval of study leave for Dr. LORD for the dates of 17/18 August 1998.

14.12.2.5. Consultants' Timetable of the Department of Medicine for Elderly People from 4.5.98 – 8.2.99.

Appendix B

Facts of the environment - obtained from the statements of Mrs RICHARDS's daughters

15. Mrs MACKENZIE is the elder of Mrs RICHARDS's two daughters. It is noted that her sister, Mrs LACK, is a retired Registered General Nurse.

15.1. Mrs LACK retired in 1996 after 41 years continuously in the nursing profession. For 25 years prior to retirement she was involved in the care of elderly people. For 20 years prior to retiring she held supervisory and managerial positions in this field of nursing.

15.2. By July 1998, Mrs RICHARDS had been resident at the Glen Heathers Nursing Home for some four years. She had a past medical history of bilateral deafness for which she required two hearing aids (unfortunately these were lost while she was at the Glen Heathers Nursing Home). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).

15.3. Also by July 1998, Mrs RICHARDS had become increasingly forgetful and less able physically. She had had 17 falls documented at the Glen Heathers Nursing Home between 29th January 1998 and 29th July 1998.

15.3.1. During this period Mrs MACKENZIE decided to meet and question her mother's general practitioner, Dr BASSETT. Mrs MACKENZIE had formed the opinion that the drugs Dr BASSETT was prescribing could contribute to her mother's confused mental state and deterioration of her physical health. One drug was Trazodone and the other was haloperidol. Following this meeting she sent him a copy of a book entitled *Toxic Psychiatry*.

15.3.2. Dr BASSETT replied, in a hand-written letter, thanking Mrs MACKENZIE and stating '... I have a reputation in Lee [-on-Solent] of being somewhat sparing with 'mood' drugs and especially antibiotics. ... most drugs are prescribed with more caution these days. [paragraph] Hopefully we can continue to keep your Mother's drugs to a minimum!'

15.4. It is convenient to mention here that both Mrs MACKENZIE and Mrs LACK have registered serious concerns about the care given to their mother in the Glen Heathers Nursing Home.

15.4.1. Jane PAGE, Principal Nursing Home Inspector, Portsmouth & S.E. Hants Health Authority investigated these concerns formally. On 11th August 1998, she made an unannounced visit to the Glen Heathers Nursing Home. She reported, on 26th August 1998, that 'From the written records obtained and discussions held, I can find no evidence to substantiate that Mrs RICHARDS did not receive appropriate care and medication.'

15.4.2. These concerns were discussed further by the Social Services Department at a meeting held on 23rd November 1998 when Mrs LACK was present. The conclusion was that 'There was no evidence of deliberate abuse [of Mrs RICHARDS] although there seemed to be problems of complacency in some of the care practices which needed review.... However, there was no evidence of malpractice by the Home.'

15.5. On 29th July 1998, while in the Glen Heathers Nursing Home, Mrs RICHARDS sustained a fracture of the neck of her right femur (thighbone). According to Mrs

LACK her mother underwent a surgical operation on 30th July 1998 'following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.'

15.6. Mrs LACK has also stated:-

15.6.1. 'My mother received a replacement hip, on her right side, and remained in the Haslar Hospital a further eleven days until Tuesday the 11th August 1998. [paragraph] I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.'

15.6.2. 'Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.'

15.6.3. 'She was with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.'

15.6.4. 'Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.'

15.6.5. 'Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.'

15.7. On 12th August 1998, the day after her mother's admission to the Gosport War Memorial Hospital, Mrs LACK visited her mother there and has recorded '... I was rather surprised to discover that I could not rouse her [Mrs RICHARDS]. As she was unrousable she could not take nourishment or be kept hydrated. [paragraph] I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days. [paragraph] I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar hospital during the period after the surgical operation to replace her hip. [paragraph] I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate the possible cause. I consider it likely that she was in need of the toilet. ... One of the

consequences of being rendered unrousable, by the effects of 'Oramorph', was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.'

15.8. Mrs RICHARDS had a fall on 13th August 1998 (as described above). On the following morning (14th August 1998), Mrs LACK noted that while her mother was being taken to the X-ray department at the Gosport War Memorial Hospital 'She was still deeply under the effects of the 'Oramorph' drug.'

15.9. As described above Mrs RICHARDS was then transferred to the Royal Hospital Haslar for the reduction of her dislocated artificial hip. She was returned to the Gosport War Memorial Hospital on 17th August 1998 having been noted the previous day (16th August) by Mrs LACK [a nurse experienced in the care of elderly people] to be 'easily manageable'.

15.9.1. In accepting that he would transfer Mrs RICHARDS to the Gosport War Memorial Hospital, Dr REID (consultant geriatrician) had stated that '... despite her dementia, she [Mrs RICHARDS] should be given the opportunity to try to re-mobilise.'

15.10. On visiting her mother at the Gosport War Memorial Hospital at about 1215 hours on 17th August 1998, Mrs LACK accompanied by her sister [Mrs MACKENZIE], found her mother to be screaming and in pain. The screaming ceased 'within minutes' when Mrs LACK and a registered general nurse repositioned Mrs Richards.

15.11. Subsequently, the X-ray at the Gosport War Memorial Hospital showed no fresh dislocation of the artificial hip.

15.12. Following this further X-ray, Mrs LACK told Dr BARTON that Haslar Hospital would be prepared to readmit her mother. Dr BARTON is reported to have '... felt that was inappropriate.' Mrs LACK '... considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.'

15.12.1. Dr BARTON is stated to have said to Mrs LACK that, '..."It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery." '

15.13. Mrs LACK states that, on 18th August 1998, the Ward Manager [Mr Philip BEED] explained to her and her sister that a syringe driver was going to be used. This was to ensure Mrs RICHARDS 'was pain free at all times' so that she would not suffer when washed, moved, or changed in the event she should become incontinent. Mrs LACK has also described in her contemporaneous notes (as well as in her Witness Statement, see below) that 'A little later Dr BARTON appeared and confirmed that a haematoma

was present and that this [the use of a syringe driver] was the kindest way to treat my mother. She [Dr BARTON] also stated "And the next thing will be a chest infection." '.

15.13.1. In her Witness Statement, Mrs LACK has recorded 'The outcome of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I [Mrs LACK] knew that the continuous use of morphine, as means of relieving her pain, could result in her death. She [Mrs RICHARDS] was, at the time, unconscious from the effects of previous doses of 'Oramorph'.... [paragraph] As result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, "Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free". [paragraph] The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998. [paragraph] A little later Dr BARTON [sic] appeared and confirmed that a haemetoma [sic] was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection." .... [In her witness statement Mrs Mackenzie has stated that ' DR BARTON [sic] then said, "Well, of course, the next thing for you to expect is a chest infection".'][paragraph] I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'. [paragraph] I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death. [paragraph] I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON [sic] more strongly on this issue. [paragraph] In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON [sic] from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and where an offer had already been made to do so. [paragraph] I accept that my mother was unwell and that her physical, reserves had been depleted. However, she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly [responsibility] it was to care for her. [paragraph] My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on 19th August and no further urine was passed. The same catheter remained in place until

her death. [paragraph] Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.'

15.14. It is noted that Mrs LACK had made contemporaneous hand-written notes comprising five numbered pages. In her Witness Statement she records these '... are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Mrs Sue HUTCHINGS [sic] on 20.8.98.'

15.14.1. Mrs LACK also made a further one page of contemporaneous hand-written notes. In these she states she was so appalled about her mother's condition, discomfort and severe pain that she visited Haslar Hospital at about lunchtime on 17th August 1998 to ask questions about her mother's condition before she [Mrs RICHARDS] had left the Haslar Hospital ward for her second transfer to Gosport War Memorial Hospital. She learned that, prior to her discharge from Haslar Hospital on 17th August 1998, her mother had been eating, drinking, using a commode and able to stand if aided. Mrs LACK also states in this contemporaneous record that 'On leaving the ward [at Haslar Hospital at about lunchtime on 17th August 1998] I bumped into the Dr [doctor] who had been in casualty theatre for my mothers [sic] second [sic] operation. He was with consultant when all the procedures were explained to me on Friday 14th [August 1998] He said "How's your mother". I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said "We've had no referral. Get them to refer her back. We'll see her."

15.15. It is noted that a Discharge Letter from the Royal Hospital Haslar describes Mrs RICHARDS' condition on discharge on 17th August 1998 as "She can, however, mobilise fully weight bearing."

15.16. It is also noted that Mrs LACK has stated that she and her sister were constantly at the Gosport War Memorial Hospital, day and night, from 17th August 1998 until the time their mother died.

15.16.1. Mrs MACKENZIE has stated that 'I stayed with my mother until very late that Tuesday night [18th August 1998]. it was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening [21st August 1998] when my mother died. During that time Dr Barton [sic] did not visit my mother. I am quite certain about this because our mother was not left alone, in her room, at

any time apart from when she was washed by the nursing staff. Either my sister or I, [sic] was with her throughout.'

15.16.2. Mrs MACKENZIE has also stated that although she did not sign the contemporaneous notes made by Mrs LACK she '... was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.'

15.16.3. Mrs MACKENZIE continues 'It seems to me that she [Mrs RICHARDS] must have had considerable reserves of strength to enable her to survive from Monday until Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before transfer to the Gosport War Memorial Hospital.'

Appendix C

Glossary

Acetabulum is the name given to the two deep socket into which the head of the thigh bone (femur) fits at the hip joint.

ADL [activities of daily living] are those physical activities of daily life necessary for normal human functioning and include getting up, washing, dressing, preparing a simple meal, etc.

Analgesia is the relief of pain. This can be achieved by physical means including warmth and comfortable positioning as well as by the use of drugs. The aim is to keep patients pain free with minimal side effects from medication.

Bronchopneumonia is inflammation of the lung usually caused by bacterial infection. Appropriate antibiotic therapy, based on the clinical situation and on microbiological studies, will result in complete recovery in the majority of patients. It can contribute to the cause of death in moribund patients.

Co-codamol is a drug mixture consisting of paracetamol and codeine phosphate, which is used for the relief of mild to moderate pain.

Cyclizine is a drug used to prevent nausea and vomiting, vertigo, and motion sickness.

Dementia is the name given to a condition associated with the acquired loss of intellect, memory, and social functioning.

Diamorphine, also known as heroin, is a powerful opioid analgesic.

Haematoma is an accumulation of blood within the tissues, which clots to form a solid swelling.

Haloperidol, a drug used in the treatment of psychoses including schizophrenia and mania and also for the short-term management of agitation, excitement, and violent or dangerously impulsive behaviour. Dosage for all indications should be individually determined and it is best initiated and titrated under close clinical supervision. For patients who are elderly the normal starting dose should be halved, followed by a gradual titration to achieve optimal response. It is not licensed for subcutaneous administration (see **licensed** below).

Hemiarthroplasty is the surgical remodelling of a part of the hip joint whereby the bone end of the femur is replaced by a metal or plastic device to create a functioning joint.

Hyoscine is a drug used to reduce secretions and it also provides a degree of amnesia and sedation, and has an anti-vomiting effect. Its side effects include drowsiness.

Lactulose is a preparation taken by mouth to relieve constipation.

A **microgram** is one millionth of a gram and is not to be confused with a milligram dosage of a drug, which is one thousand times larger.

Midazolam is a sedative drug about which there have been reports of respiratory depression. It has to be use with caution in elderly people. It is used for intravenous sedative cover for minor surgical procedures. It is also used for sedation by intravenous injection in critically ill patients in intensive care. It can be given intramuscularly. In the management of overdosage special attention should be paid to the respiratory and cardiovascular functions in intensive care. It is not licensed for subcutaneous administration (see **licensed** above).

Morphine is an opioid analgesic used to relieve severe pain.

Oramorph is a drug used in the treatment of chronic pain. It contains morphine and is in the form of a liquid. 10mls of Oramorph at a strength of 10mgs of morphine sulphate in 5mls of liquid is an appropriate first dose to give to a person in severe pain, which had not responded to other less potent, pain relieving drugs.

Respiratory depression is the impairment of breathing by drugs or mechanical means which leads to asphyxia and, if uncorrected, to death.

Subcutaneous means beneath the skin.

A **syringe driver** is a power driven device for pushing the plunger of a syringe forward at an accurately controlled rate. It is an aid to administering medicinal preparations in liquid form over much longer periods than could be achieved by injecting by hand. In this case the syringe driver used was a Sims Graseby MS 26 Daily rate syringe driver which operates over periods of 24-hours.

Tradazone is a drug used in the treatment of depressive illness, particularly when sedation is required.

Unlicensed medicines. In order to ensure that medicines are safe, effective and of suitable quality, they must have a product licence (now called a market authorisation) before being marketed in the United Kingdom. Unlicensed drugs are not licensed for use for any indication or age group. Licensing arrangements constrain pharmaceutical companies but not prescribers. The Medicines Act 1968 and European legislation make provision for doctors to use unlicensed medicines. Individual prescribers of unlicensed medicines, however, are always responsible for ensuring that there is adequate information to support the quality, efficacy, safety and intended use of a drug before using it.

A **Zimmer frame** is a lightweight, but sturdy, frame the patient can use for support to assist safe walking.

APPENDIX D

Texts used for reference have included:

1. Adam J. ABC of palliative care: The last 48 hours. *British Medical Journal* 1997; 315: 1600-1603.

    1.1. This paper is from the widely read, British Medical Journal which is published weekly and received by about 30,000 general practitioners and 45,000 hospital doctors in England and Wales. It records that treatment with opioids (viz. morphine and diamorphine) should be individually tailored, the effect reviewed, and the dose titrated accordingly.

2. *ABPI Compendium of data sheets and summaries of product characteristics 1998-99: with the code of practice for the Pharmaceutical Industry*. Datapharm Publications Limited, 12 Whitehall, London SW1A 2DY.

3. Breggin P R. *Toxic psychiatry. Drugs and electroconvulsive therapy: the truth and the better alternatives*. 1993. HarperCollins Publishers. London. pp. 578.

4. British Medical Association and the Royal Pharmaceutical Society of Great Britain. *British National Formulary*. Number 32 (September 1996). The Pharmaceutical Press. Oxford.

5. *Cecil Textbook of Medicine*. eds. J.C. Bennett & F. Plum. W.B. Saunders Co. 20th Edition. 1996.

6. Letter from Clive Ward-Able (Medical and Healthcare Director) and Lee Neubauer BSc (Hons) (New Product Specialist), Roche Pharmaceuticals.

    6.1. A copy of this letter has already been supplied to the Police and reports that the product licence does not cover the administration of Hypnovel® (midazolam) by subcutaneous injection.

7. Roche Pharmaceuticals. Hypnovel® [midazolam]. Summary of product characteristics.

8. Letter from Dr R J Donnelly, Medical Director of Janssen-Cilag Ltd.

    8.1. A copy of this letter has already been supplied to the Police and reports that Haldol™ decanoate (haloperidol) is not licensed for subcutaneous use.

9. Letter from Miss Jo Medlock, Manager of Medical Information and Pharmacovigilance, Norton Pharmaceuticals.

    9.1. A copy of this letter has already been supplied to the Police and reports that Serenace™ (haloperidol) ampoules are not licensed for subcutaneous administration.

10. MeReC. Pain control in palliative care. *MeReC Bulletin National Prescribing Centre*. 1996; 7 (7); 25-28.

    10.1. MeReC is the abbreviation for the 'Medicines Resource Centre'. This bulletin is sent free to all general practitioners in England and Wales and also to NHS Hospital and Community Pharmacists. The list of those who receive this bulletin is updated every few weeks.

11. Sims Graseby Limited. *MS 16A Syringe Driver. MS 26 Syringe Driver: Instruction manual*. Sims Graseby Limited. 1998.

Appendix E

The writer's qualifications and experience including the management of dying patients

Code A

Code A

Code A

References as numbered above:

1. Livesley B, Ellington S. Report on the independent comprehensive review of the care of elderly people at St. Christopher's Nursing Home, Hatfield. East and North Hertfordshire Health Authority, 1996. (by invitation)

2. Livesley B. Memorandum of recommendations and evidence submitted to the Health Committee on long-term care provision and funding. Volume II; pp. 114-22. London: HMSO, 1996. (by invitation)

signed ..Code A.. date 10 July 2001
BRIAN LIVESLEY

Frimley Park Hospital NHS
NHS Trust

Portsmouth Road
Frimley
Camberley
Surrey
GU16 7UJ

Tel: 01276 604604
Fax: 01276 604148

Elderly Care Unit
Code A *direct line)*
nto Secretaries' office)

KIM/gnt/gosport

18 October 2001

CONFIDENTIAL

Detective Superintendent J James
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
PORTSMOUTH
PO2 8BU

Dear DS James

CONFIDENTIAL MEDICAL REPORT REGARDING MEDICAL MANAGEMENT OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

Thank you for asking me to give a report on the management of four patients who died at Gosport War Memorial Hospital. I have based my personal opinion on my qualification as a specialist in geriatric medicine, my 13 years experience as a Consultant Geriatrician with several years experience working at the local hospice.

USE OF OPIOID ANALGESICS

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. The guidance in the BNF suggests that non-opioid analgesics such as Aspirin or Paracetamol should be used as first line treatment and occasionally non-steroidal anti-inflammatory drugs may help in the control of bone secondaries. If these drugs are inadequate to control the pain of moderate severity then a weak opioid such as Codeine or Dextropropoxyphene should be used either alone or in combination with the simple pain killers in adequate dosage. If these weak opioid preparations are not controlling the pain Morphine is the most useful opioid analgesic and is normally given by mouth as an oral solution every 4 hours, starting with a dose between 5 mg and 20 mg, the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and use of other drugs should also be considered. If the pain is not well controlled the dose should be increased in a step-wise fashion to control the pain.

Sometimes modified release preparations of Morphine are given twice daily once the required dose of Morphine is established, as this may be more convenient for the patient.

If the patient becomes unable to swallow the equivalent intra-muscular dose of Morphine is half the total 24 hour dose given orally. Diamorphine is preferred for injections over Morphine as it is more soluble and can be given in smaller volume, therefore with less distress to the patient.

Subcutaneous infusions of Diamorphine by syringe driver are standard practise if the patient requires repeated intra-muscular injections, to save the patient unnecessary distress. This is standard treatment in Hospices and other medications can be added to deal with anxiety, agitation and nausea as they can safely be mixed with Diamorphine (such as Haloperidol, Cyclizine and Midazolam). The other indications for use of the parenteral route are when the patient is unable to take medicines by mouth due to upper gastro-intestinal problems and occasionally if the patient does not wish to take regular medication by mouth.

The BNF has a table showing the equivalent doses of oral Morphine and parenteral Diamorphine for intramuscular injection or subcutaneous infusion as a guide to the dosage when switching from the oral to the injection route, eg 10 mg of oral Morphine 4 hourly is equivalent to 20 mg of Diamorphine by a subcutaneous infusion every 24 hours, and 100 mg oral Morphine 4 hourly is equivalent to 240 mg of Diamorphine subcutaneously every 24 hours.

SUMMARY

It is clear from the above that a doctor trying to control pain should first start the patient on a non-opioid analgesic, move on to a weak opioid analgesic if the pain is not controlled, consider changing the patient to regular oral Morphine if the pain remains poorly controlled and only start parenteral Diamorphine if the patient is unable (or unwilling) to take Morphine by mouth and would otherwise need regular painful injections of Diamorphine to try and control the pain. There is clear guidance on the dose of Morphine to use in a syringe driver when transferring from oral Morphine to the subcutaneous route. Finally the dose of Morphine or Diamorphine should be reviewed regularly and only increased if the symptom of pain is not adequately controlled.

CASE NOTE REVIEWS

1 ARTHUR CUNNINGHAM

Mr Cunningham was known to suffer with depression, Parkinson's disease and cognitive impairment with poor short term memory. He suffered with long standing low back pain following a spinal injury sustained in the Second World War which required a spinal fusion. He suffered with hypertension and non insulin diabetes mellitus, had a previous right renal stone removed, and bladder stones, and had a previous trans-urethral prostatectomy. Myelodysplasia had been diagnosed (a bone marrow problem affecting the production of the blood constituents). Mr Cunningham had a one month admission under the care of Dr Banks for depression in July and August 1998.

Mr Cunningham was admitted by Dr Lord, Consultant Geriatrician from the Dolphin Day Hospital to Dryad Ward at Gosport War Memorial Hospital on 21 09 1998 because of a large necrotic sacral ulcer with a necrotic area over the left outer aspect of the ankle (these are signs of pressure sores). Dr Lord's intention was to give more aggressive treatment to the sacral ulcer. He was seen by Dr Barton. A dose of 2.5 mg to 10 mg of Oromorph 4 hourly was prescribed and he was given 5 mg prior to his sacral wound dressing at 1450 and a further dose of 10 mg at 2015. Diamorphine via a syringe driver was prescribed at a dose of 20 mg to 200 mg in 24 hours and this was commenced at a dose of 20 mg for 24 hours with Midazolam at 2300 on 21 09 1998. Dr Barton reviewed the patient on 23 September when he was said to be "chesty", Hyoscine was added to the syringe driver and the dose of Midazolam was increased. The patient was noted to be in some discomfort when moved on that day and the next day he was said to be "in pain" and the Diamorphine dose was increased to 40 mg for 24 hours, then 60 mg the following day and 80 mg on the 26 September, there being no further comments as to the patient's condition. The dose of Midazolam and Hyoscine was also increased. The patient died at 2315 on 26 09 1998.

Comments

All the prescriptions for opiod analgesia are written in the same hand, and I assume they are Dr Barton's 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 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. The patient was reviewed by Dr Barton 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.

2 ALICE WILKIE

Miss Wilkie was known to suffer with severe dementia, depression and rectal bleeding attributed to piles. She had been admitted to Philip Ward with a urinary tract infection and immobility under the care of Dr Lord and a decision was made to transfer her to Daedalus ward at Gosport War Memorial Hospital for a few weeks observation prior to a decision on placement. She was transferred on the 6 August and was seen by Dr Peters. The nurses recorded that the patient was complaining of pain but it was difficult to establish the nature or site of this pain. Diamorphine was prescribed on 20 08 1998 in a dose of 20 mg to 200 mg per 24 hours and the signature is identical to that on Mr Cunningham's case which I assume is Dr Barton's. A dose of 30 mg was given on 20 08 1998 with Midazolam and an entry in the notes, again apparently by Dr Barton, comments on a "marked deterioration over last few days". The patient was given another 30 mg of Diamorphine on 21 08 1998 and died that day at 1830. The patient was said to be comfortable and pain free by the nursing staff on the final day.

Comments

There was no clear indication for an opiod 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.

3 ROBERT WILSON

Mr Wilson was known to suffer with alcohol abuse with gastritis, hypothyroidism and heart failure. He was originally admitted via Accident & Emergency on the 22 September with a fractured left humerus and transferred to Dickens Ward under the care of Dr Lord. His fracture was managed conservatively. In view of the severe pain he received several doses of Morphine and was prescribed regular Paracetamol.

He was reviewed by Dr Luznat, Consultant Psychogeriatrician, who felt he had an early dementia and depression and recommended an anti-depressant. He was also noted to have poor nutrition.

Dr Lord made a decision to transfer Mr Wilson for a "short spell to a long term NHS bed" with the aim of controlling his pain and presumably to try to rehabilitate him. He was accordingly moved to Dryad ward at Gosport War Memorial Hospital on the 14 October. The transfer letter from Dickens

ward shows that he was still " in a lot of pain in arm".

The prescription appears to have been written by Dr Barton once again. Paracetamol was prescribed but never given by the nursing staff. Oramorph was prescribed 10 mg 4 hourly and 20 mg nocte commencing on 15 10 1998 and the night time dose was given with "good effect" as judged by the nursing staff. The nursing report goes on to say that Mr Wilson had become "chesty" and had "difficulty in swallowing medications". Oramorph was also prescribed 5 mg to 10 mg as required 4 hourly and four doses were given, suggesting Mr Wilson was in persisting pain. on 16 10 1998 the patient was seen by Dr Knapman. The patient was said to be unwell, breathless, unresponsive with gross swelling of the arms and legs. No ECG or oxygen saturation was recorded but the patient's dose of Frusemide (a diuretic) was increased, so I assume the patient was thought to have worsening heart failure. The nurses report a "very bubbly chest". A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16 10 1998 again, in Dr Barton's handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of Diamorphine was given on 16 10 1998 and the nurses commented later that the "patient appears comfortable", the dose was increased to 40 mg the next day when copious secretions were suctioned from Mr Wilson's chest. On 18 10 1998 the patient was seen by Dr Peters and the dose of Diamorphine was increased to 60 mg in 24 hours and Midazolam and Hyoscine were added. The patient died on 18 10 1998 at 2340 hours.

Comments

Mr Wilson was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given (there was an entry earlier in the episode of care that Mr Wilson had refused Paracetamol). No other analgesia was tried prior to starting morphine. Mr Wilson 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 again the Diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson'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 Dr Lord on 29 09 1998.

4 EVA PAGE

Mrs Page was 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. She was admitted on 06 02 1998 to Victory Ward with nausea, anorexia and dehydration and had recently been treated for depression. She was transferred to Charles Ward on 19 02 1998 and had been noted to have a 5 cm mass on chest

x-ray compatible with a lung cancer. She was transferred to Dryad ward, Gosport Memorial Hospital on 27 02 1998 for palliative care. On arrival she was noted to be calling out frequently, and anxious. She was prescribed Thioridazine (a tranquilliser) but this did not relieve her distress and she was prescribed Oramorph 5 mg to 10 mg as required 4 hourly, I believe, by Dr Barton. The nurses report "no relief". She was seen by another doctor who was not named in the nursing record who prescribed regular Thioridazine and Heminevrin at night. On 01 03 1998 it is recorded that Mrs Page "spat out medication", on 02 03 1998 there was an entry, I believe by Dr Barton, stating "no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain". He prescribed a Fentanyl patch 25 mg (another opioid which can be given as a skin patch) and the prescription was countersigned by Dr Lord, I believe. The nursing records state she was "very distressed", she was reviewed by Dr Barton and Diamorphine 5 mg intramuscularly was given. She was then seen by Dr Lord and a further dose of intramuscular 5 mg Diamorphine was given. On 03 03 1998 a syringe driver was started, prescribed, I believe, by Dr Barton, at a dose of 20 mg to 200 mg in 24 hours. The initial dose given was 20 mg of Diamorphine with Midazolam which was started at 1050. The nurses record "rapid deterioration .... right side flaccid" . The patient died at 2130 that evening.

Comments

Mrs Page 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 she was given a topical 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 was clear that her physical condition deteriorated rapidly and I suspect 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 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 chart is, in my view, unacceptable. In my view the dose of Diamorphine should be prescribed on a regular basis and reviewed regularly by 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 dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Dr Lord and Dr Barton 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 prescriber did not comply with standard practise. 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 require further consideration by the Hospital Trust.

I trust this report contains all the essential information you require. Please let me know if you wish me to give any further comment.

Yours sincerely

Code A

DR K I MUNDY FRCP
CONSULTANT PHYSICIAN AND GERIATRICIAN

In reply please quote 2000/2047

Please address your reply to the Committee Section, FPD
Fax 020 7915 7406

25 February 2002

Special Delivery

Dr J A Barton

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Dr Barton

I am writing to notify you that a person referred to in rule 4(1) ("the medical screener") of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1998[(a)] has considered, information received by the GMC about your conduct.

Copies of the information received are attached and listed at page 2 of the enclosed bundle of papers.

The screener, 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 in order that it may consider whether it is necessary for the protection of the 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(1) of the Medical Act 1983 as amended.

The screener has reached this decision after considering that the information received from Hampshire Constabulary is of such a nature that it may be both in the public interest and in your own interest that your registration to be restricted whilst those matters are resolved.

You are invited to appear before the Committee at 09.30 on 21 March 2002 at the Council's offices at 44 Hallam Street, London, W1, 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 Committee is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

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 Adam Elliott, Committee Section (fax no 020 7915 7406).

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 Interim Orders Committee 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 Adam Elliott, 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 Adam Elliott (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.

I enclose copies of the relevant provisions of the Medical Act, the Interim Orders Committee Procedure Rules, a paper about our fitness to practice procedures and a paper about the procedures of the Interim Orders Committee.

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 all of your current employers including any locum agencies with whom you are registered, and the hospital or surgery at which you currently work. 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 or hospital by which you are employed, or have any working arrangements. Please return this information in the envelope provided.

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

Code A

Gerry Leighton
Assistant Registrar

Your ref: RIR/cmp

Our ref: 2000/2047

25 February 2002

First Class Post

Dr R I Reid
Medical Director
Portsmouth Healthcare NHS Trust
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Dr Reid

Dr Jane Barton

Further to our previous communication, I am writing to notify you that on 21 March 2002, in accordance with Section 41A(2) of the Medical Act 1983 as amended, the Council's Interim Orders Committee (IOC) is scheduled to consider information provided by Hampshire Constabulary concerning the deaths of 5 patients at Gosport War Memorial Hospital. The IOC has the power to suspend or impose interim conditions on Dr Barton's registration until such time as the issues raised by this information are resolved.

We shall inform you of the Committee's decisions once known. If, in the meantime, I can be of any further assistance, please don't hesitate to contact me.

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Your ref: PO/JD/021302jb.doc

Our ref: 2000/2047

25 February 2002

First Class Post

Dr Peter Old
Acting Chief Executive
Isle of Wight, Portsmouth &
South East Hants Health Authority
Finchdean House
Milton Road
Portsmouth PO3 6DP

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Dr Old

Dr Jane Barton

Further to our previous communication, I am writing to notify you that on 21 March 2002, in accordance with Section 41A(2) of the Medical Act 1983 as amended, the Council's Interim Orders Committee (IOC) is scheduled to consider information provided by Hampshire Constabulary concerning the deaths of 5 patients at Gosport War Memorial Hospital. The IOC has the power to suspend or impose interim conditions on Dr Barton's registration until such time as the issues raised by this information are resolved.

We shall inform you of the Committee's decisions once known. If, in the meantime, I can be of any further assistance, please don't hesitate to contact me.

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

IOC REFERRALS

DOCTORS FULL NAME : Jane Ann BARTON
FPD REFERENCE : 2000/2047
CASE WORKER : Mike Hudspith (ext 3617)
DOCTOR'S PLACE OF PRACTICE: Southampton area – currently practising with locally agreed restrictions
DOCTORS SPECIALITY : General Practice
DATE OF REFERRAL TO IOC : 14/02/02
REFERRED BY : Dr Lewis
MEMBER(S) THAT HAVE SEEN CASE: Dr Lewis and IOC panel on 21/06/01
SUMMARY OF ALLEGATIONS : Dr Barton is a General Practitioner who was also engaged by Portsmouth Healthcare NHS Trust as a visiting clinical assistant at Gosport War Memorial Hospital. Concerns about Dr Barton's use of pain relieving drugs became the subject of a police investigation into the unlawful killing of elderly patients at Gosport War Memorial Hospital. The case was considered by the IOC in June 2001. At that time the police investigation was at an early stage and only 1 death was being investigated. The information available to the Committee was therefore limited. The Committee decided to make no order. The police investigation is now over. No charges were brought but the police case papers were forwarded to the GMC for consideration. The information now in our possession refers to 5 deaths, all of which are covered by 'expert' reports. The papers have been reviewed by the screener who considers that the new information is of such a nature that the case warrants the referral back to the IOC.

GMC100829-0231

Isle of Wight, Portsmouth and South East Hampshire NHS
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Switchboard: 023 9283 8340
Direct Dial: Code A

From Fax Number: 023 9283 5197

PRIVATE & CONFIDENTIAL

FAX TRANSMISSION

TO:	Mr Hudspith	
TO FAX NUMBER:	Code A	DATE: 21 February 2002
FROM:	Dr Peter Old	PAGE 1 OF 2

If you do not receive all pages of this fax, please phone 023 9283 5000 immediately Thank you

MESSAGE:

Dear Mr Hudspith

Following our recent telephone conversation please find attached letter to Dr Barton as promised.

Regards

Dr Peter Old
Acting Chief Executive

Isle of Wight, Portsmouth and South East Hampshire NHS

Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Direct Line
Direct Fax Code A

Our Ref: PO/JD/021302jb.doc

13 February 2002

Private & Confidential
Dr Jane Barton

Code A

Dear Dr Barton

Following our meeting last night I wish to set out the basis of our agreement. I have shared this letter with Dr Ian Reid since it relates, in part, to the Gosport War Memorial Hospital.

- We agreed that you would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital.
- We agreed that you would voluntarily stop prescribing opiates and benzodiazepines with immediate effect.
- We were unable to put a timescale on these restrictions but agreed to review the situation monthly.

In view of the anticipated press interest, the Health Authority and Portsmouth HealthCare NHS Trust have prepared a draft statement which we have attached for your perusal.

Many thanks for your co-operation.

Yours sincerely

Code A

pp. Dr Peter Old
Acting Chief Executive
Email Address: Code A

Attachment

Isle of Wight, Portsmouth and South East Hampshire NHS
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Switchboard: 023 9283 8340
Direct Dial: Code A

From Fax Number: 023 9283 5197

STRICTLY PRIVATE & CONFIDENTIAL
FAX TRANSMISSION

TO:	Michael Hudspith	
TO FAX NUMBER:	020 7915 3642	**DATE:** 15 March 2002
FROM:	Dr Peter Old	**PAGE 1 OF** 3

If you do not receive all pages of this fax, please phone 023 9283 5000 immediately
Thank you

MESSAGE:

As per our telephone conversation please find attached letters to Dr Jane Barton.

Regards

Peter Old

Isle of Wight, Portsmouth and South East Hampshire NHS
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Direct Line
Direct Fax Code A

Our Ref: PO/JD/021302jb.doc

13 February 2002

Private & Confidential
Dr Jane Barton
Code A

Dear Dr Barton

Following our meeting last night I wish to set out the basis of our agreement. I have shared this letter with Dr Ian Reid since it relates, in part, to the Gosport War Memorial Hospital.

- We agreed that you would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital.
- We agreed that you would voluntarily stop prescribing opiates and benzodiazepines with immediate effect.
- We were unable to put a timescale on these restrictions but agreed to review the situation monthly.

In view of the anticipated press interest, the Health Authority and Portsmouth HealthCare NHS Trust have prepared a draft statement which we have attached for your perusal.

Many thanks for your co-operation.

Yours sincerely

Code A

pp Dr Peter Old
Acting Chief Executive
Email Address: Code A

Attachment

GMC100829-0235

Isle of Wight, Portsmouth and South East Hampshire NHS

Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Direct Line
Direct Fax Code A

Our Ref: PO/JD/031502jb.doc

15 March 2002

Private & Confidential
Dr Jane Barton

Code A

Dear ~~Dr Barton~~ Jane

I wrote to you on 13 February 2002 setting out our agreement on restrictions to your medical practice. At that time it was not possible to put a timescale on these restrictions, but we agreed to review the situation monthly.

I understand that you are due to appear before the GMC in the very near future. Therefore I propose that we continue with the current restrictions until we have the result of the GMC's deliberations.

Thank you for your continued co-operation.

Yours sincerely

Code A

Dr Peter Old
Acting Chief Executive
Email Address Code A

cc: Michael Hudspith, GMC

Please quote our reference when communicating with us about this matter

Our ref: Code A
Your ref:
14 March 2002

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Code A
Lambeth

Legal Department of The MDU

Freephone: 0800
Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: Code A
Website www.the-mdu.com

Mr Adam Elliott
Committee Co-ordinator
Interim Orders Committee Secretariat
General Medical Council
178 Great Portland Street
London, W1W 5JF

Dear Adam

Interim Orders Committee 09:30 on 21st March 2002

I write with reference to your letter to my client Dr Barton of 12th March and the forthcoming hearing before the Interim Orders Committee at 9.30am on 21st March 2002. Can I confirm through this letter that I act on her behalf, and that she will be represented by me and by Mr Alan Jenkins of Counsel at the forthcoming hearing.

Please do not hesitate to contact me if I can be of further assistance.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

D1.

Consultant Geriatricians
Specialist Registrars
Professor Severs
Ward Managers Jersey House/George ward/Jubilee House/Briarwood ward/ Shannon ward/Cedar ward/Daedalus ward/[redacted]
Chrissie Immins & Medical Secs

Our ref DJ/LB
Your ref
Date 16 February 2000
Ext 6920

Dear Colleague

The bed crisis at Queen Alexandra hospital continues unabated. Routine surgical operations have been cancelled now. It has fallen on us to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some underutilisation 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. We shall trial the flexible use of the beds for a few weeks and I would be happy to co-ordinate any comments.

Thank you for your help.

Yours sincerely

Code A

DAVID JARRETT FRCP

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

Queen Alexandra Hospital
Cosham, Portsmouth, Hants PO6 3LY

Enc 2

EMERGENCY USE OF COMMUNITY HOSPITAL BEDS

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. Some continuing care beds remain underutilised in Petersfield Community Hospital, Gosport War Memorial Hospital and St Christopher's Hospital Fareham. These beds have no resident medical staff and weekly, or less than weekly, Consultant ward rounds. There is basic nursing care and only minimal rehabilitation staff and facilities.

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

1. Waiting for placement having had a full care management assessment
2. Medically stable with no need for regular medical monitoring
3. No outstanding investigations or need for close medical or nursing monitoring
4. No interventional therapy such as intravenous lines or need for IV medication
5. The patient lives near the community hospital and/or are willing to go there for temporary placement awaiting permanent placement
6. The patient and family consent to the move
7. The patient, family and staff of referring ward clearly understand that the placement is in a post acute bed, not continuing care bed; this placement does not entitle patient to NHS continuing care
8. GP beds in community hospitals are independent of the department's continuing care provision and their flexible use should be negotiated with the *patient's general practitioner*

This policy will be operational from 16.2.00 and will be reviewed after one month. Linda Butchers in the Elderly Medicine Offices will keep a list of names of patients from referring ward and consultant, discharge destination and any problems encountered.

Dr David Jarrett
Elderly Medicine
Portsmouth Healthcare Trust

Dr Jane Barton
Clinical Assistant in Elderly Services
The Surgery
148, Forton Road
Gosport
HANTS PO123HH
Code A

22nd February 2000

CLINICAL ASSISTANT ELDERLY MEDICINE GOSPORT WAR MEMORIAL HOSPITAL

I was very disappointed and also quite concerned to be shown a letter from yourself dated the 16th 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 consultant or seamless locum consultant cover for a period of a further month on one of the wards and the other consultant cannot be expected to provide anything other than firefighting support during this time.

As a result I am unable to do the clinical Assistant 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 understilisation in a unit which is handling approximately 40% or the continuing care dontby Elderly Services at this time.

I hope you will give this serious consideration,

Yours Sincerely

Dr Jane Barton
Clinical Assistant
Elderly Medicine
Gosport War Memorial Hospital
Gosport
Hants

DJ/MW

07 March 2000

6590

Dear Jane

RE: CLINICAL ASSISTANT ELDERLY MEDICINE GWMH

Thank you for your letter dated from the 22nd February making me aware of your concerns about the use of continuing care wards.

My original letter was an attempt to ease some of the acute pressures at Queen Alexandra Hospital. As you know there are a huge number of elderly patients as outliers who are blocking the surgical beds. There has effectively been little elective surgery from the Christmas crisis period.

A brief survey, a few weeks ago showed that there were some continuing care beds that were unfilled.

After discussion between John Bevan and my consultant colleagues, we felt it might help the dire situation here if we used some of those unfilled continuing care beds for patients who are clinically stable and awaiting placement in say a rest home or nursing home. It was envisaged that the patients would require little medical input and that we would only move patients who they themselves and their families were happy to the move.

I understand that the continuing care workload at Gosport War Memorial Hospital is quite large certainly in comparison with other community hospitals. Gosport is busy in other areas with an ever increasing number of referrals from Haslar hospital and an increasing need for consultant input to the GP beds. With that in mind we will need to look at ways of trying to improve consultant cover for the Gosport peninsula. I will try and incorporate this into our plans to try and expand consultant numbers.

Thank you for letting me know of your concerns.

Yours sincerely

David Jarrett

IOC Attendance Sheet E

Doctor present and represented by Counsel/QC

Dr Barton is present and is represented by Mr Jenkins, Counsel, instructed by the Medical Defence Union.

Mr Lloyd, Counsel, instructed by the Solicitor to the Council, represents the Council.

Enclosure (2)

Dr.JA Barton
Clinical Assistant in Elderly Services
148, Forton Road
Gosport
Code A

28th April 2000

Peter King
Personnel Director
Portsmouth Healthcare trust
St James Hospital
Portsmouth PO48LD

References:
a. My letter 28.1.2000 to Clinical Director Elderly Medicine
b. My letter 22.2.2000 to Dr David Jarrett (copies of both letters attached)

Dear Peter,
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 consultant 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.
My original contract of employment signed in 1993 indicates I am required to give you two months notice. However, I wish my serious concerns and anxieties to be placed on record during the notice period.
Yours sincerely,

Jane Barton
Copies to:
M Millett
Dr I Reid
Dr A Lord

Private & Confidential

Our ref
FC/LD
Your ref

Date
19 May 2000
Ext
214

Dr J Barton
The Surgery
148 Forton Road
GOSPORT
PO12 3HH

Dear Jane,

I have been passed a copy of your letter of 28th April 2000 tendering your resignation from the post of Clinical Assistant in Elderly Services at Gosport War memorial, to which I believe Peter King has formally responded.

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.

Acceptance of the above pressures coupled with your resignation has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and pressures arising. The paper proposes enhanced medical input and rationale for that, which is in keeping with current intermediate care discussions.

I hope that you will be able to give your support to this proposal, given your knowledge of the current situation, when the paper is presented to the PCG.

My thanks for your contribution to Gosport War Memorial Hospital and my good wishes for continued success in your other roles.

Yours sincerely

Code A

Fiona Cameron
Divisional General Manager

Encl 6.

GUIDELINES FOR ADMISSION TO DAEDALUS WARD
(COMMUNITY REHABILITATION)

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday 21 March 2002

Case of
BARTON, Jane Ann [*Conduct Case*]

T. A. REED & CO

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday 21 March 2002

PROFESSOR NORMAN MACKAY in the Chair

Case of
BARTON, Jane Ann

DR BARTON was present and was represented by MR A JENKINS of counsel, instructed by the Medical Defence Union.

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

A

[The Chairman introduced those present to Dr Barton and her legal representatives.]

MR LLOYD: Dr Barton 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 Gladys Richards 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 two daughters, the medical notes of Mrs Richards and exculpatory statements by Dr Barton herself, and by Dr Lord, the consultant geriatrician of the ward to which Mrs Richards 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 Dr Barton 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.

B

C

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

D

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 Dr Barton and, in the light of those matters, it has been referred back to this Committee.

E

At the relevant time Dr Barton was working as a clinical assistant in elderly medicine at Gosport War Memorial Hospital. Can I deal with the reports, first of all insofar as they relate to Gladys Richards? Mrs Richards 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.

F

Professor Livesley'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 Mrs Richards was not in pain on 11 August 1998, she was prescribed wide dosage ranges of opiate and sedative drugs to which Mrs Richards 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 21st. During that time at no time did Dr Barton appropriately review Mrs Richards' condition. Also, thirdly, during this period there is no record of Mrs Richards being given fluids as food in an appropriate manner.

G

H

A

So far as Dr Ford's 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,

B

> "During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Barton. 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, Arthur Cunningham. 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 Doctors Mundy and Ford. Dr Mundy'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.

C

D

So far as Dr Ford is concerned, his report into the case of Mr Cunningham 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.

E

> "The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham 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."

F

Moving on to the case of Alice Wilkie, 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. Dr Mundy deals with this patient at page 331 of the Committee's bundle and his comments are these:

G

> "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".

H

Dr Ford deals with this at pages 355 to 358. His conclusion at 358 is this:

A

> "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 Robert Wilson, 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.

B

Dr Mundy deals with that at pages 331 to 332. He has no significant criticism of Dr Barton.

Dr Ford 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.

C

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

At paragraph 5.12,

D

> "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,

E

> "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 Eva Page. 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. Dr Mundy 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.

F

Dr Ford 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,

G

> "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 Dr Barton on 3 March. In my view this was an inappropriate, potentially hazardous prescription".

H

That deals with the reports of those three experts.

A

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.

B

It is clear that Dr Barton 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.

C

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.

D

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.

THE CHAIRMAN: There may be questions from members of the panel.

E

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

MR LLOYD: 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.

F

MR WARDELL: There is another matter, and it may be that Mr Jenkins 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 Dr Lord'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 consultant in charge. Are we entitled to know whether that particular consultant 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 consultant.

G

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

H

A

THE CHAIRMAN: The working relationship between Dr Lord and Dr Barton might be explored through Mr Jenkins.

In the absence of further questions, Mr Jenkins, would you like to begin?

MR JENKINS: Sir, what I propose to do is ask Dr Barton to give evidence before you.

B

JANE ANN BARTON, Sworn
Examined by MR JENKINS

Q Dr Barton, 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.

C

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 clinical assistant 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?

D

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.

E

A The health care trust allocated me five clinical assistant 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 clinical assistant 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.

F

G

Dryad ward had no consultant cover for the 10 months that you are considering these cases. Dr Lord 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?

H

A Yes.

A

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.

B

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.

C

Q How many other doctors would be there throughout the day to treat these 48 patients if all the beds were full?
A None.

D

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.

E

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.

F

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.

G

H

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

A

Q Tell us how.

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.

B

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.

C

Q That is an indication of the requirements made of nursing staff?

A Nursing requirements. They could not do anything for themselves, basically.

D

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 Althea was left to attempt to help me with both, although she was not officially in charge.

E

Q Althea is...?

A Dr Lord, the other consultant.

F

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.

G

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.

H

T A Reed & Co

A

Q You have told us that over a 10-month period there was no consultant 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.

B

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.

C

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.

D

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.

E

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.

F

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

G

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----

H

T A Reed & Co

A

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.

B

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.

C

Q Are you – perhaps I can use the expression – up to date in developments locally in primary care and matters of that nature?

D

A I was also, at the time of these allegations, chairman 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 clinical assistant, 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.

E

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.

F

Q We will come to some correspondence shortly. After you resigned, your job was taken over by another doctor?

G

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 clinical assistant sessions?
A In three and a half clinical assistant sessions. It is just a measure of the difference in the complexity and the workload that is being put into a cottage hospital.

H

A

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?

B

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.

C

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

A Yes.

D

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?

E

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 acting clinical director 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.

F

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?

G

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?

H

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

A

comment on how much input the Trust put into improving their skills. I think that would be inappropriate for me to do.

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?

B

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?

C

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.

D

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.

E

F

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.

G

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.

H

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.

T A Reed
& Co

A

Q What we see again and again in the comments of Professor Ford 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 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.

B

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

C

> "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".

D

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.

E

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".

F

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

G

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

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

H

Q ...in the cottage hospital.
A No.

T A Reed & Co

A

Q It may be that Professor Ford believed that you were permanent staff.
A Failed junior staff! His last comment in paragraph 7.5 – his review of Dr Lord'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.

B

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 Professor Ford's next paragraph. He says,

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

C

– 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?

D

A I find it very upsetting. I was only a clinical assistant. 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.

E

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 acting chief executive, Dr Old. 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?

F

A Yes.

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

G

Q Had you not agreed those, were you threatened with any action?
A Dr Old 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.

H

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

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.

B

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.

C

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.

D

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".

E

A Yes.

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

F

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

THE CHAIRMAN: We will refer to it as D1. [*Same handed*]

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

G

THE CHAIRMAN: I assume they have been circulated. Shall we put them in chronological order?

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

H

A

> "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,

B

> "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".

C

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:

D

> 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 Dr Barton dated 22 February to Dr Jarrett. The letter reads,

E

> "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.

F

> 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.

G

> I find myself without a consultant or seamless locum consultant cover for a period of a further month on one of the wards, and the other consultant cannot be expected to provide anything other than firefighting support during this time.
>
> As a result, I am unable to do the clinical assistant 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

H

T A Reed
& Co

A

> 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".

B

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

C

The next document is the one with the fax strips down the centre of it. It is a letter from Dr Barton dated 28 April 2000, tendering her resignation. It is addressed to Peter King, personnel director, 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.

D

> 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 consultant 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.

E

> 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.

F

The last letter, dated 19 May from Fiona Cameron, 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".

G

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

H

THE CHAIRMAN: Mr Lloyd, do you wish to ask questions?

A

THE LEGAL ASSESSOR: I have no questions, sir.

Questioned by the COMMITTEE

DR RANSON: Did you have consultant cover during 1998?
A I had a lady called Dr Jane Tandy, who became pregnant, who commenced her annual leave on 27 April 1998 and followed on with maternity leave from 1 June until 8 February 1999. So basically she was very pregnant, and then she was gone for the rest of the year.

B

Q And no replacement or locum cover?
A No.

C

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

MR WARDELL: 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!

D

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.

E

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.

F

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.

G

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

H

Q Was that your total involvement with the hospital?

A

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.

B

Q Mr Jenkins 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".

C

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.

D

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?

E

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.

F

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.

G

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.

H

MR WINTER: 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

A

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.

B

Dr Lord 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.

C

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

D

THE CHAIRMAN: 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.

E

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.

F

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.

G

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

H

T A Reed & Co

A

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.

B

Q We are aware of how the Gladys Richards 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? [*Dr Barton conferred with counsel*]

MR JENKINS: Sir, you will recall from what I said to an earlier constitution of this Committee that the relatives of Gladys Richards 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.

C

D

DR BARTON: 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.

E

THE CHAIRMAN: Technically, as a clinical assistant 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.

F

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.

G

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.

H

Q Were there any audit meetings in the hospital?
A I did not go. I was not invited to go to audit meetings.

A

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 clinical assistant 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.

B

C

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?

D

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

THE CHAIRMAN: 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, Mr Jenkins?

E

MR JENKINS: There is one, sir, and it was raised by Mr Lloyd. Do you have any private patients?
A No.

MR JENKINS: 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.

F

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 Dr Barton'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 Professor Ford and the other doctors that they were well aware that Dr Barton 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.

G

H

A

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? Dr Barton 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.

B

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.

C

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 Dr Barton'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.

D

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 Dr Barton has voluntarily agreed with the health authority.

E

Those are the submissions that I make.

THE CHAIRMAN: I now turn to the legal assessor.

F

THE LEGAL ASSESSOR: 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.

G

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

MR JENKINS: Sir, I have mentioned the little green book with which Dr Barton has helped. I leave it with you.

H

THE CHAIRMAN: Thank you.

A

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

The parties having been readmitted:

B

THE CHAIRMAN: Dr Barton, 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 under Section 41A of the Medical Act 1983 as amended should be made in relation to your registration.

C

D

E

F

G

H

E:\C\IOC\FOLLOWUP\2002\MARCH\BARTON

In reply please quote NV/HJ/MHu//FPD/2000/2047

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

25 March 2002

Detective Sergeant R J Burt
Hampshire Constabulary
Major Incident Complex Police Station
Kingston Complex
Portsmouth
Hampshire PO2 8BU

Dear DS Burt

Dr Jane Ann Barton, BM BCh 1972 Oxfd
Registration Code A

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting 21 March 2002.

Dr Barton attended the meeting, and was legally represented.

After considering submissions from Counsel instructed by the GMC, and also from Dr Barton's legal representatives, the IOC considered that it was **not** necessary for the protection of members of the public and in the public interests or in Dr Barton's own interests to make an order affecting her registration.

Yours sincerely

Code A

Nilla Varsani
Committee Section

Code A

E:\C\IOC\FOLLOWUP\2002\MARCH\BARTON

In reply please quote NV/HJ/MHu//FPD/2000/2047

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

25 March 2002

Special Delivery

Dr J A Barton

Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Dr Barton

Notification of Decision of the Interim Orders Committee

On 21 March 2002 the Interim Orders Committee of the GMC considered whether it was necessary for the protection of members of the public or was otherwise in the public interest or in your own interests to make an Order under Section 41A(1) of the Medical Act 1983 as amended (the Act).

You were present at the meeting, and were represented by Mr Jenkins, Counsel, instructed by the Medical Defence Union.

At the conclusion of the proceedings of the Interim Orders Committee in your case on 21 March 2002 the Chairman announced the Committee's determination as follows:

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

Yours sincerely

Code A

Scott Geddes
Assistant Registrar

cc: Mr Barker, The MDU, 230 Blackfriars Road, London SE1 8PT [Ref: ISPB/TOC/0005940/Legal]

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org

Michael Hudspith

E:\C\IOC\FOLLOWUP\2002\MARCH\BARTON

In reply please quote **NV/HJ/MHu//FPD/2000/2047**

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

25 March 2002

Dr P Old
Acting Chief Executive
Isle of Wight, Portsmouth & SE Hampshire HA
Finchdean House
Milton Road
Portsmouth PO3 6DP

Dear Dr Old

Dr Jane Ann Barton, BM BCh 1972 Oxfd
Registration No: Code A

I am writing to you in connection with Dr Barton.

The GMC's Interim Orders Committee (IOC) considered the case of Dr Barton at its meeting 21 March 2002.

Dr Barton attended the meeting, and was legally represented.

After considering submissions from Counsel instructed by the GMC, and also from Dr Barton's legal representatives, the IOC considered that it was **not** necessary for the protection of members of the public and in the public interests or in Dr Barton's own interests to make an order affecting her registration.

Yours sincerely

Code A

Nilla Varsani
Committee Section

Code A

E\Committee\IOC\Followup\2002\March\NHSExec

In reply please quote **NV/HJ/IOC/FPD/21Mar02**

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

25 March 2002

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Mrs Barbara Carter
NHS Executive
Room 2W10
Quarry House
Leeds LS2 7UE

Dear Mrs Carter

I am writing to confirm the decisions taken by the GMC's Interim Orders Committee at its meeting on 21 March 2002. The decisions were as follows:

Name: BARTON, Jane Ann
Registration Number: 1587920
Qualifications: BM BCh 1972 Oxfd
Registered address: **Code A**

Decision: The Committee directed that no order be made.

Name: LATIF, Surraya Wajahat *(formerly Nabi, S Ghulam)*
Registration number: 1482812
Qualifications: MB BS 1961 Punjab SR
Registered address: **Code A**

Decision: The Committee directed that no order be made.

Name: HOLDSWORTH, Darren Scott
Registration number: 4614560
Qualifications: MB ChB 1999 Glasg
Registered address: **Code A**

Decision: The Committee reviewed the order for interim conditions imposed on 14 December 2001 and directed that for the remainder of the duration of the order Dr Holdsworth's registration should be suspended.
(until 13 June 2003)

Name: BIHARI, Kailash
Registration Number: 2363635
Qualifications: MB BS 1973 Patna
Registered address: Code A

Decision: The Committee directed that no order should be made.

New orders made by the Committee are subject to review within six months. Orders which have been reviewed will be subject to review within three months.

Yours sincerely

Code A

Nilla Varsani
Committee Secretary
Code A

cc: Angela Hawley, NHS Executive

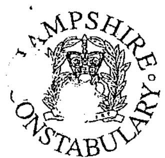
Dr Barton

IOC 21 March 2002

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

Michael Hudspith



HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM

Your Ref. : NV/HJ/Mhu/FPD/2000/2047

Tel. : 0845 045 45 45
Direct Dial :
Fax. : 02392 891562

08 April 2002

Ms Varsani
Committee Section
General Medical Council
178 Portland Street
LONDON
W1W 5JE

Dear Ms Varsani

I am writing in response to your letter of the 25th March addressed to Detective Sergeant BURT concerning Dr Jane Anne BARTON, which has been forwarded for my attention.

I have noted the contents of your letter regarding the outcome of the meeting of the 21st March.

For your information I am now the officer with responsibility for any enquiries concerning Dr BARTON and any correspondence should be addressed as shown on this letterhead.

Yours sincerely

Code A

J JAMES
Detective Superintendent

CRIMESTOPPERS 0800 555 111

29 Foster Road
Alverstoke
Gosport
Hampshire
PO12 2JH

Friday 17th May 2002

Tel: Home 02392 365555
Work Code A

The Director
Mr Mike Hudspith
The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr Hudspith

RE: GOSPORT WAR MEMORIAL – DEATH OF Mrs E I PAGE

I wish to make a formal complaint against two doctors working at The Gosport War Memorial in Gosport, Hampshire, during the time that my mother was in their care. The doctors concerned are **Dr's A LORD and Jane A BARTON** Code A

My mother was admitted from Queen Alexandra's Hospital, Portsmouth on 27th Feb 1998 and died the evening of the 3rd of March 1998.

The events leading up and including her death were investigated in a serious crimes investigation carried out by The Major Incident Complex, Portsmouth. Her case was serious enough to be sent to medical experts for opinion, I believe this report substantiates concern in her treatment. I also believe you have a copy and am aware of this case.

It is important to note that I was first made aware that there was concern in the treatment of elderly patients during 1998, when Mrs Gillian MacKenzies's case made local press news. At that time I wrote a letter to the police stating that I had concern relating to my mother, this was on the 9th April 2001. I was told that my mother's case would be investigated. I heard nothing until the 13 February 2002. At that time I was invited with other concerned relatives to a meeting with the head of the enquiry team who explained the events of the investigation and the reasons as to why no further action would be taken. At this meeting I first learnt that my mother's case was one of four cases investigated and expert opinions sought. I was also told at this meeting that these reports would be available to me. This promise was rescinded, and I was told later that Court Orders would be required, and this may well be refused.

I subsequently obtained my mothers notes and after perusal with a professional opinion, I found several grave areas of concern. I now understand from Mrs Ann Reeves (another unhappy relative) that these police reports were sent to you and you have/are investigating further.

I am annoyed that throughout this time I have been kept in the dark by the police as to any investigation made, and the investigating officers decision to take no further action, and his subsequent withdraw of the offer to release the medical opinions. I am presently making a formal complaint to The Chief Constable, Hampshire Police.

I trust you are able to assist me in this very serious matter.

Yours truly,

Code A

Bernard Page

Page letter GMC

In reply please quote MH/ Misc

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

21 May 2002

Mr Bernard Page

Code A

Dear Mr Page

Re: Gosport War Memorial – Death of Mrs E I Page

Thank you for your letter of 17 May 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Hudspith and he will be in contact as soon as possible.

Yours sincerely

Code A

Desrine Emmanuel
Caseworker Assistant
For Michael Hudspith (Senior Caseworker)
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

29 Foster Road
Alverstoke
Gosport
Hampshire
PO12 2JH

Tuesday 21st May 2002

Tel: Home 02392 365555
Work Code A

The Director
Mr Mike Hudspith
The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr Hudspith

RE: GOSPORT WAR MEMORIAL – DEATH OF Mrs E I PAGE

Thank you for your call on Monday and for the briefing you gave me.

As we discussed I write to formally request all relevant documents you have appertaining to my mother's death.

Yours faithfully

Code A

Bernard Page

Michael Hudspith Code A

From: Susan Graham Code A
Sent: 21 Jun 2002 10:50
To: Michael Hudspith Code A
Subject: RE: Disclosure of expert report to relatives of deceased patients

Yes, it would still be open to the relatives to seek a court order. Under DPA, it is OK to provide personal data to a third party if we are required to do so by a court order.

Susan.

-----Original Message-----
From: Michael Hudspith Code A
Sent: 21 Jun 2002 10:48
To: Susan Graham Code A
Subject: RE: Disclosure of expert report to relatives of deceased patients

Thanks for looking at this Susan.

Would it still be open for the relatives to seek a court order requiring disclosure?

Mike

-----Original Message-----
From: Susan Graham Code A
Sent: 21 Jun 2002 10:21
To: Michael Hudspith Code A
Subject: Disclosure of expert report to relatives of deceased patients

Mike

I have read the sections of the expert's report at flags D and F, which relate to Alice Wilkie, Robert Wilson and Eva Page. I am concerned that some of the paragraphs in the report relate, not only to the patients, but also to the medical staff concerned, particularly Dr Barton. Under the Data Protection Act, the deceased do not have rights, but the living do. If we disclose these paragraphs of the report, we may violate Dr Barton's rights as a data subject.

The paragraphs I am particularly concerned about are: 4.8, 4.9, 4.11. 4.13, 4.14, 5.9, 5.12, 5.15, 5.17, 5.18, 6.13, 6.15, 6.17, 6.18.

In view of this, my recommendation is that we do not disclose the report as we need to respect Dr Barton's rights as a data subject.

Susan.

PS I will bring your file back upstairs.

Your reference:

Our reference: 2000/2047

21 June 2002

First Class Post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Mr Bernard Page

Code A

Dear Mr Page

Mrs Eva Page

I write further to your letter of 17 May 2002 and our recent telephone conversations regarding your mother's case. Please accept my apologies for the delay in responding.

I have now had an opportunity to speak with Hampshire Constabulary and taken advice from both senior colleagues and our own solicitors about disclosing to you copies of the expert opinions prepared during the recent police investigation.

As with all record holders, the GMC is bound by the terms and conditions of the Data Protection Act 1998 when deciding how and why personal data is processed. Personal data is information about identifiable, living individuals and includes both facts and opinions about the individual. Processing incorporates the concepts of 'obtaining', holding' and 'disclosing' information.

I am advised that, were we to release these documents to you, we may be violating the rights of data subjects (certain individuals named in the documents). I am afraid therefore that due to restrictions placed upon us by the Data Protection Act we are unable, at this time, to disclose the information you have requested.

That said, I am also advised that under the Data Protection Act we can provide personal information to a third party if required to do so by a court order. Should you wish to consider pursuing this option, you should approach a solicitor for advice.

I am sorry that I can not be of further help at this time.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No 1089278

246 Kings Drive
Eastbourne
East Sussex
BN21 2XE

28th May 2002

Mr M. Hudspith
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Mr Hudspith,

Mrs Gladys Richards

As progress is being made with your enquires regarding the conduct of medical staff at the Gosport War Memorial Hospital I wish the following concerns to be put on record.

When I approached the Gosport C.I.D. on 2 October 1998 I alleged a case of gross negligence manslaughter relating to the death of my mother, Mrs Gladys Richards. I quoted the points of law to be proved following Lord MacKay's ruling in 1995 concerning the case of Adomako. At that time I had not seen the medical files.

As you are aware the second investigation commencing in October 1999 revealed the contents of the files to me. I subsequently alleged a more serious situation as it appeared to me there was written indication of 'intent'. I am still of that opinion. The total disregard of Dr. Ian Reid's letter dated 5 August 1998 and the discharge letter from Haslar dated 10 August 1998 constitutes more than negligence. In addition the discharge note from Haslar dated 17 August 1998 indicates my mother was once more mobile. The medical files are now in your possession and you are aware of the grave issues raised. The P.C.A. upheld all my complaints relating to 'investigative failures' in the first investigation by Gosport C.I.D. I understand a similar situation has arisen relating to cases brought to the attention of police in 2001 and formal complaints have been lodged with the Chief Constable.

I am aware of the boundaries set for the G.M.C. and cases are not referred to the criminal court. However the patterns set in my mother's case and apparently followed in approximately nine other cases (to date) are such that I feel very strongly they should be dealt with in a Court of Law. A recent remark in a conversation with a police officer "Juries do not like to convict Doctors" says something of the intelligence of the average jury and the explanation of the law by an unbiased judge – let alone the Obiter Dicta by a Judge (Mars – Jones/Carr) (1986)

I hope your legal panel will bear this in mind and make recommendations accordingly before deciding on a hearing only before the G.M.C. I understand that a hearing would be open to the public with press coverage and this could bar a case being heard in the criminal court.

Yours sincerely

Code A

Gillian. M. MacKenzie

Copies:
RT Hon David Blunkett MP
Paul Kernaghan Chief Constable
Nigel Waterson MP Eastbourne
Peter Viggers MP Gosport
Duncan Geer PCA
Paul Close CPS London
David Parry Treasury Counsel

In reply please quote Mhu/FPD/2000/2047

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

5 June 2002

Ms Gillian M MacKenzie

Code A

Dear Ms MacKenzie

Re: Mrs Gladys Richards

Thank you for your letter of 28 May 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Hudspith and he will be in contact as soon as possible.

Yours sincerely

Code A

Desrine Emmanuel
Caseworker Assistant
For Michael Hudspith (Senior Caseworker)
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Tel. 01329-284661

28 June 2002

Mr M HUDSPITH
British Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr HUDSPITH,

WAR MEMORIAL HOSPITAL, GOSPORT

It has been brought to my attention that you are involved in an investigation into various members of the medical staff at the above hospital in late 1998, and feel you should be aware of the untimely death of my step-father in September of that year whilst under its care, if you do not know already.

My step-father was Arthur Denis Brian CUNNINGHAM, who was admitted into this hospital on 21 September with serious bed-sores, as outlined in various papers sent by me to the Hampshire Constabulary some considerable time ago. He died on 26 September, apparently from Bronchopneumonia.

For my own peace of mind, I would like you to take account of Mr CUNNINGHAM's case along with the others, and I will be pleased to assist your enquiries in any way possible. To this end, I would be readily available for a personal interview in your office during most of July and August, as I will be residing in London during that period.

I look forward to hearing from you.

Yours faithfully,

Code A

C R S FARTHING

In reply please quote MH/GWMH/misc

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

1 July 2002

Mr C R S Farthing

Code A

Dear Mr Farthing

War Memorial Hospital, Gosport

Thank you for your letter of 21 February 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Hudspith and he will be in contact as soon as possible.

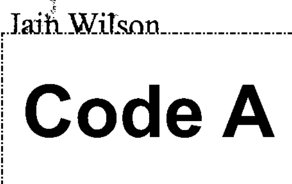
Yours sincerely

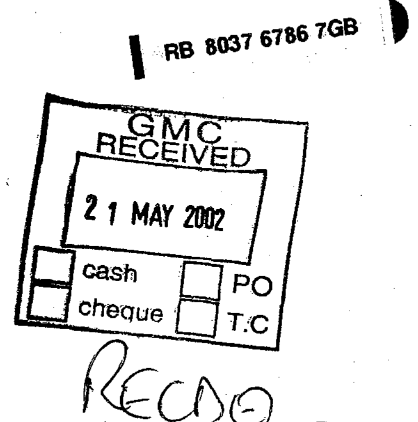
Code A

Desrine Emmanuel
Caseworker Assistant
For Michael Hudspith (Senior Caseworker)
Fitness to Practise Directorate
Phone: 020 7915 3603
Fax: 020 7915 3642

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Iain Wilson





18th May 2002

The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Sir,

Regarding the death of my Father Robert Caldwell Wilson at the Gosport War Memorial Hospital on 18th October 1998.

I wish to make a formal complaint against Dr Jane Barton and Gill Hamblin, who were I believe, responsible for my fathers care, administration of drugs and his death.

My father's death has been investigated by Hampshire police and by two medical experts, the information of their findings is in a secret report now held by Hampshire police.

I wish to be kept fully informed with regards this complaint and the eventual outcome.

If I can be of any further help please do not hesitate to contact me.

Yours sincerely

Iain Wilson.

Iain Wilson

Code A

30th June 2002

Mr Michael Hudspith
Fitness to Practice directorate
The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Sir,

Please find enclosed a copy of my letter regarding the unlawful killing of my father and my wish to make a formal complaint against the Doctor and Sister responsible for his health and ultimately his death at the Gosport War Memorial Hospital on the 18th October 1998. This letter was dated 18th May 2002 and sent by recorded delivery, to the General Medical Council.

This week I phoned the GMC as I have not received a reply or indeed an acknowledgement to my letter to be told that my complaint had not been received, and that there were in fact, no complaints against Dr Jane Barton.

This I do not believe and in fact, all that has been done is the same as in other relatives complaints regarding deaths at this hospital at the hand of this Doctor, my formal complaint has been deliberately mislaid.

Please confirm receipt of this letter and that my formal complaint has been received and will be acted upon.

I wish to be kept fully informed about this matter and any hearings with regard this Doctor.

I await your early reply

Yours Sincerely

Code A

Iain Wilson

Iain Wilson
Code A

COPY LETTER

18th May 2002

The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Sir,

Regarding the death of my Father Robert Caldwell Wilson at the Gosport War Memorial Hospital on 18th October 1998.

I wish to make a formal complaint against Dr Jane Barton and Gill Hamblin, who were I believe, responsible for my fathers care, administration of drugs and his death.

My father's death has been investigated by Hampshire police and by two medical experts, the information of their findings is in a secret report now held by Hampshire police.

I wish to be kept fully informed with regards this complaint and the eventual outcome.

If I can be of any further help please do not hesitate to contact me.

Yours sincerely

Iain Wilson.

In reply please quote MH/GWMH/misc

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

3 July 2002

Mr Iain Wilson
Code A

Dear Mr Wilson

Thank you for your letter and enclosures of 30 June 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Hudspith and he will be in contact as soon as possible.

Yours sincerely

Code A

Desrine Emmanuel
Fitness to Practise Directorate
Code A
Fax: 020 7915 3642

In reply please quote 2000/2047

Please address your reply to the Fitness to Practise Directorate
Fax: 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

11 July 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

A member of the Council, who is appointed under Rule 4 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 to give initial consideration to cases, has asked me to notify you, under rule 6(3) of those Rules, that the Council has received from Hampshire Constabulary information which appears to raise a question whether, as a registered medical practitioner, you have committed serious professional misconduct within the meaning of section 36(1) of the Medical Act 1983. A copy of the relevant provisions of the Act is enclosed, together with copies of the Procedure Rules, the GMC's publication "Good Medical Practice" and of a paper about the GMC's fitness to practise processes.

In the information it is alleged that:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs Wilkie's rehabilitation needs;

4. a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Copies of information from Hampshire Constabulary may be found in the enclosed bundle of papers which is indexed at page 2.

The member has directed, in accordance with the Procedure Rules, that the information received from Hampshire Constabulary be referred to the Preliminary Proceedings Committee of the Council. That Committee will consider the information any written explanation provided by you, to determine whether the case should be referred to the Professional Conduct Committee of the Council for inquiry into a charge against you.

You are invited to submit at your earliest convenience a written explanation of the foregoing matter. The next meeting of the Preliminary Proceedings Committee will be held on 29 - 30 August 2002. It is in your interests that the Committee should have time to give careful consideration to any explanation you may wish to offer. You may therefore find it helpful to know that any explanation received by the Council before 21 August 2002 will be circulated to the Committee before the meeting. Any explanation received between 21 and 29 August 2002 will be placed before the Committee on the day of the meeting. Please address your explanation for the attention of Lorna Johnston, Conduct Case Presentation Team, fax number: **Code A**

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 10 days of receipt of this letter, of the name and address of all of your current employers including the Health Authority with which you have a service agreement, any locum agencies with whom you are registered, and the hospital or 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 or hospital by which you are employed, or have any working arrangements. If you are approved under Section 12 of the Mental Health Act, you must also notify us of this fact.

I enclose a form for you to complete and return in the envelope provided. 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. **Failure to comply with this statutory requirement may result in further proceedings against you.**

The documents enclosed with this letter may contain confidential material. This material is sent to you solely to enable you to respond to the allegations in this letter: it 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 shown above.

Yours sincerely

Code A

Gerry Leighton
Assistant Registrar

Code A

Michael Hudspith (7915 3617)

From: Michael Hudspith (7915 3617)
Sent: 11 Jul 2002 12:56
To: FPD Disclosure
Subject: Dr Jane Barton (PPC - 29/08/02)

Importance: High

Dr Barton's case is scheduled to be considered by the PPC at their meeting on **29 - 30 August 2002**

FPD case ref no.: 2000/2047

Dr's reg. no.: 1587920

Nature of Conduct: Substandard clinical practice and care

Notification sent to Dr: 11 July 2002

Charges

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs

Wilkie's rehabilitation needs;

a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr. Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dr Peter Old
Acting Chief Executive
Isle of Wight, Portsmouth and
South East Hampshire Health Authority
Finchdean House
Milton Road
Portsmouth PO3 6DP

Dear Dr Old

Dr Jane Barton Code A

I write further to our previous correspondence regarding Dr Barton.

I am now able to confirm that a case against Dr Barton based on the information received Hampshire Constabulary is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your ref:

In reply please quote: 2000/2047

11 July 2002

GENERAL
MEDICAL
COUNCIL
Protecting patients, guiding doctors

First Class Post

Dr R I Reid
Department of Elderly Medicine
South Block
Queen Alexandra Hospital
Portsmouth
PO6 3LY

Dear Dr Reid

Dr Jane Barton Code A

I write further to our previous correspondence regarding Dr Barton.

I am now able to confirm that a case against Dr Barton based on the information received Hampshire Constabulary is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

Mr Bernard Page

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear Mr Page

Gosport War Memorial Hospital

I write further to your letter of 17 May 2002 regarding the death of your mother, Eva Page. I am sorry that I have not been able to update you fully on our consideration of this case before now.

As you are aware, following the conclusion of their investigation, Hampshire Constabulary forwarded their case papers to the GMC for us to consider whether action under our fitness to practise procedures was warranted against any individual doctors.

These papers have been carefully considered and, in relation to Mrs Page's clinical management, it was decided that the reported actions of Dr Lord did not raises any issues serious enough to warrant the restriction or removal of her registration. As such, we do not intend taking any further action against her.

I can confirm, however, that a case against Dr Jane Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that no issue of serious professional misconduct is raised by these allegations, they may conclude the matter by issuing a warning or advisory letter to Dr Barton about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

Iain Wilson

Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Wilson

Dr Jane Barton **Code A**

I write further to your previous letters of 18 May and 30 June 2002. I apologise for the delay in responding and for the apparently false information you were given when you telephoned this office.

I should begin by explaining that that GMC only has jurisdiction over doctors. We are therefore unable to consider a compliant about Sister Hamblin. Should you wish to pursue a complaint about Sister Hamblin you should write to the Nursing and Midwifery Council at 23 Portland Place London W1B 1PZ.

As you are aware, following the conclusion of their investigation, Hampshire Constabulary forwarded their case papers to the GMC for us to consider whether action under our fitness to practise procedures was warranted against any individual doctors.

I am now able to confirm that, in relation to the information relating to Mr Wilson's clinical care, a case against Dr Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate
Code A
Fax Line: 020 7915 3642
Code A

Your ref: MIC/Det.Supt/JJ/DM

In reply please quote: 2000/2047

11 July 2002

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

First Class Post

Det Supt John James
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
Portsmouth PO2 8BU

Dear Det Supt James

Dr Jane Ann Barton Code A

I write further to our previous correspondence concerning Dr Barton.

I am now able to confirm that the information forwarded by Hampshire Constabulary concerning Dr Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that no issue of serious professional misconduct is raised by these allegations, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your ref:

In reply please quote: 2000/2047

11 July 2002

First Class Post

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Mr C R S Farthing

Code A

Dear Mr Farthing

Gosport War Memorial Hospital

I write further to your letter of 28 June 2002 regarding the death of your step father, Arthur Cunningham.

As you may be aware, following the conclusion of their investigation, Hampshire Constabulary forwarded their case papers to the GMC for us to consider whether action under our fitness to practise procedures was warranted against any individual doctors.

I am now able to confirm that, as a result of information received about Mr Cunningham's clinical management, a case against Dr Jane Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that the case raises no issue of serious professional misconduct, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Your ref:

In reply please quote: 2000/2047

11 July 2002

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

First Class Post

Mrs G MacKenzie

Code A

Dear Mrs MacKenzie

Dr Jane Ann Barton **Code A**

I write further to our previous correspondence and telephone conversations about Dr Barton.

I am now able to confirm that the information forwarded by Hampshire Constabulary concerning Dr Barton is scheduled to be considered on 29 - 30 August 2002 at a meeting of the Council's Preliminary Proceedings Committee. It will be for that Committee to decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

Should the Committee decide that no issue of serious professional misconduct is raised by these allegations, they may conclude the matter by issuing a warning or advisory letter to the doctor about her future conduct, or decide to take no action. Please note that the relevant Trusts and Health Authorities have also been notified. We will write to you again after the Committee meeting to inform you of our decision.

As the Council's deliberations at this stage of our procedures is private, I would ask you not to disclose this information to any other persons.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

syringe driver a device to ensure that a syringe releases medicine over a defined length of time into the body.

terminal care care given in the last weeks of life.

terms of reference the rules by which a committee or group does its work.

trust board a group of about 12 people who are responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and directors.

Unison Britain's biggest trade union. Members are people working in the public services.

United Kingdom Central Council (UKCC) on 1 April 2002 the UKCC ceased to exist. Its successor body is The Nursing and Midwifery Council (NMC). Its purpose was to protect the public through establishing and monitoring professional standards.

ward round A regular review of each patient conducted by a consultant, often accompanied by nursing, pharmacy and therapy staff.

Wessex palliative care guidelines local guidance to help GPs, community nurses and hospital staff as well as specialist palliative care teams. It provides a checklist for management of common problems in palliative care, with some information on medical treatment. It is not a comprehensive textbook.

whistle blowing the act of informing a designated person in an organisation that patients are at risk (in the eyes of the person blowing the whistle). This also includes systems and processes that indirectly affect patient care.

whistle blowing policy a plan of action for a person to inform on someone or to put a stop to something.

Printed in the United Kingdom by The Stationery Office
07/02 745413 19585

Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

JULY 2002

COMMISSION FOR HEALTH IMPROVEMENT

GMC100829-0307

Published by TSO (The Stationery Office) and available from:

Online
www.tso.co.uk/bookshop

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/General enquiries: 0870 600 5522
Fax orders: 0870 600 5533
E-mail: book.orders@tso.co.uk
Textphone 0870 240 3701

TSO Shops
123 Kingsway, London, WC2B 6PQ
020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
0121 236 9696 Fax 0121 236 9699
9-21 Princess Street, Manchester M60 8AS
0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
18-19 High Street, Cardiff CF10 1PT
029 2039 5548 Fax 029 2038 4347
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

TSO Accredited Agents
(see Yellow Pages)

and through good booksellers

© Commission for Health Improvement 2002

Items may be reproduced free of charge in any format or medium provided that they are not for commercial resale. This consent is subject to the material being reproduced accurately and provided that it is not used in a derogatory manner or misleading context.
The material should be acknowledged as © 2002 Commission for Health Improvement and the title of the document specified.

Applications for reproduction should be made in writing to
Chief Executive, Commission for Health Improvement, 103-105 Bunhill Row, London EC1Y 8TG.

A CIP catalogue record for this book is available from the British Library.
A Library of Congress CIP catalogue record has been applied for.

First published 2002

ISBN 0 11 703023 6

powers. They were set up in response to the Department of Health's *Shifting the Balance of Power* and took over many health authority functions. PCTs are responsible for

- improving the health of their population
- integrating and developing primary care services
- directly providing community health services
- commissioning secondary care services

PCTs are increasingly working with other PCTs, local government partners, the voluntary sector, within clinical networks and with 'shared service organisations' in order to fulfil their roles.

level four PCT brings together commissioning of secondary care services and primary care development with the provision of community health services. They are able to commission and provide services, run community health services, employ the necessary staff, and own property.

PRN (Pro re nata) prescribing medication as and when required.

protocol a policy or strategy which defines appropriate action.

psychiatrist a doctor who specialises in the diagnosis and treatment of mental health problems.

regional office see NHS regional office above.

rehabilitation the treatment of residual illness or disability which includes a whole range of exercise and therapies with the aim of increasing a patient's independence.

resuscitation a range of procedures used when someone has suddenly become seriously ill in a way that threatens their life.

risk assessment an examination of the risks associated with a particular service or procedure.

risk management understanding the various risks involved and systematically taking steps to ensure that the risks are minimized.

Royal College of Nursing (RCN) the world's largest professional union of nurses. Run by nurses, it campaigns on the part of the profession, provides higher education and promotes research, quality and practice development through the RCN institute.

sensory disabilities people who have problems hearing, seeing, smelling or with touch.

specialist a clinician most able to progress a patient's diagnosis and treatment or to refer a patient when appropriate.

speech and language therapist professionally trained person who assists, diagnoses and treats the whole spectrum of acquired or developmental communication disorders.

staff grade a full qualified doctor who is neither a General Practitioner nor a consultant.

staff grade doctors doctors who have completed their training but do not have the qualifications to enable them to progress to consultant level. Also called trust grade doctors.

stakeholders a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation. In the case of hospital trusts, it includes patients, carers, staff, unions, voluntary organisations, community health councils, social services, health authorities, GPs, primary care groups and trusts in England, local health groups in Wales.

statutory/statute refers to legislation passed by Parliament.

strategic health authority organisations that will replace health authorities and some functions of Department of Health regional offices in 2002. Unlike current health authorities, they will not be involved in commissioning services from the NHS. Instead they will performance manage PCTs and NHS trusts and lead strategic developments in the NHS. Full details of the planned changes are in the Department of Health document, Shifting the Balance of Power, July 2001.

strategy a long term plan for success.

subcutaneous beneath the skin.

swallowing assessments the technique to access the ability of the patient to swallow safely.

GMC100829-0308

National Service Framework (NSF) guidelines for the health service from the Department of Health on how to manage and treat specific conditions, or specific groups of patients e.g. Coronary Heart Disease, Mental Health, NSF for older people. Their implementation across the NHS is monitored by CHI.

neuroleptic see antipsychotics.

neurology a branch of medicine concerned with medical treatment of disorders of the nervous system.

NHS regional office

NHS trust a self governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.

Nursing and Midwifery Council The Nursing Midwifery Council (NMC) is an organisation set up by Parliament to ensure nurses, midwives and health visitors provide appropriate standards of care to their patients and clients. All qualified nurses, midwives and health visitors are required to be members of the NMC in order to practice.

nursing director the term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing throughout the trust.

occupational therapist a trained professional (an allied health professional) who works with patients to assess and develop daily living skills and social skills.

ombudsman see national health service ombudsman above.

opiates a group of medicines containing or derived from opium, that act to relieve severe pain or induce sleep.

opioid a description applied to medicines that cause similar effects in the body to opiates.

outpatient services provided for patients who do not stay overnight in hospital.

pain management a particular type of treatment that concentrates on managing a patient's pain – rather than seeking to cure their underlying condition – and complements their treatment plan.

palliative a term applied to the treatment of incurable diseases, in which the aim is to mitigate the sufferings of the patient, not to effect a cure.

palliative care care for people with chronic or life threatening conditions from which they will not recover. It concentrates on symptom control and family support to help people have as much independence and quality of life as is possible.

patient administration system (PAS) a networked information system used in NHS trusts to record information and inpatient and outpatient activity.

patient advice and liaison service (PALS) a new service proposed in the July 2000 NHS plan due to be in place by 2002, that will offer patients an avenue to seek advice or complain about their hospital care.

patient centred care a system of care or treatment is organised around the needs of the patient.

patient involvement the amount of participation that a patient (or patients) can have in their care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

primary care family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

PCG Organisations now almost completely replaced by primary care trusts. Set up in 1997, PCGs were new organisations (technically Health Authority committees) that brought together all primary care practices in a particular area. PCGs were led by primary care professionals but with lay and social services representation. PCGs were expected to develop local primary health care services and work to improve the health of their populations. Some PCGs additionally took responsibility for commissioning secondary care services.

PCT Organisations that bring together all primary care practices in an area. PCTs are diverse and complex organisations. Unlike PCGs, which came before them, they are independent NHS bodies with greater responsibilities and

Contents

Acknowledgements v
Executive summary vii

1. Terms of reference and process of investigation 1

Terms of reference 1
CHI's investigation team 2
The investigation process 2

2. Background to the investigation 4

Events surrounding the CHI investigation 4
Complaints to the trust 5
Action taken by the health authority 5
Action taken by the NHS South East regional officials 6

3. National and local context 7

National context 7
Trust background 7
Local services for older people 8
Service performance management 9
Inpatient services for older people at the Gosport War Memorial Hospital 1998–2002 9
Terminology 10

4. Arrangements for the prescription, administration, review and recording of medicines 12

Police inquiry and expert witness reports 12
Medicine usage 13
Prescription writing policy 17
Administration of medicines 17
Structure of pharmacy 19

5. Quality of care and the patient experience 21

Introduction 21
Patient experience 21
Stakeholder views 21
Outcome of CHI observation work 23

GMC100829-0309

6. Staffing arrangements and responsibility for patient care 27

Responsibility for patient care 27
Clinical assistant role 28
Appraisal and supervision of clinical assistants 29
Sultan ward 29
Out of hours cover provided by GPs 29
Appraisal of hospital medical staff 30
Nursing responsibility 30
Nursing supervision 30
Teamworking 31
Allied health professional structures 31
Workforce and service planning 32
Access to specialist advice 32
Staff welfare 33

7. Lessons learnt from complaints 35

External review of complaints 35
Complaint handling 35
Trust learning regarding prescribing 36
Other trust lessons 37
Monitoring and trend identification 37

8. Clinical governance 39

Introduction 39
Clinical governance structures 39
Risk management 40
Raising concerns 41
Clinical audit 41

Appendices 43

A. Documents received by CHI and/or referred to in the report 43
B. Views from patients and relatives/friends 54
C. Portsmouth Healthcare NHS Trust staff and non executive directors interviewed by CHI 57
D. Meetings or telephone interviews with external agencies with an involvement in elderly care at Gosport War Memorial Hospital 59
E. Medical case note review team: terms of reference and membership 61
F. Report of the Gosport investigation medical notes review group 63
G. An explanation of the dissolution of services in the new primary care trusts 65
H. Patient throughput data 1997/1998 - 2000/2001 66
I. Breakdown of medication in Dryad, Sultan and Daedalus wards Gosport War Memorial Hospital 67
J. Glossary 69

General Medical Council (GMC) the professional body for medical doctors which licenses them to practice.

general practitioner (GP) a family doctor, usually patients' first point of contact with the health service.

geriatrician a doctor who specialises in diagnosis and treatment of diseases affecting older people.

haloperidol see antipsychotics.

health authority (HA) statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities.

health community or health economy all organisations with an interest in health in one area including the community health councils, and voluntary and statutory organisations.

Health Service Ombudsman investigates complaints about failures in NHS hospitals or community health services, about care and treatment, and about local NHS family doctor, dental, pharmacy or optical services. Anyone may refer a complaint but normally only if a full investigation through the NHS complaints system has been carried out first.

holistic a method of medical care in which patients are treated as a whole and which takes into account their physical and mental state as well as social background rather than just treating the disease alone.

hyocine a medicine to relieve nausea and sickness.

Improving Working Lives a Department of Health initiative launched in 1999. It includes standards for developing modern employment services, putting in place work/life balance schemes and involving and developing staff.

incident reporting system a system which requires clinical staff to report all matters relating to patient care where there has been a special problem.

independent review stage two of the formal NHS complaints procedure, it consists of a panel, usually three members, who look at the issues surrounding a complaint.

intermediate care a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.

intranet an organisation's own internal internet which is usually private.

investigation – by CHI an in depth examination of an organisation where a serious problem has been identified.

Investors in People a national quality standard which sets a level of good practice for improving an organisation's performance through its people.

lay member a person from outside the NHS who brings an independent voice to CHI's work.

local medical committee (LMC) a group of local GPs, elected by the entire local GP population who meet with the health authority to help plan resources and inform decisions.

locum a temporary practitioner who stands in for the permanent one.

medical the branches of medicine concerned with treatment through careful use of medicines as opposed to (surgical) operations.

medical director the term usually used for a doctor at trust board level (a statutory post) responsible for all issues relating to doctors and medical and surgical issues throughout the trust.

midazolam see benzodiazepines.

multidisciplinary from different professional backgrounds within healthcare (e.g. nurse, consultant, physiotherapist) concerned with the treatment and care of patients.

multidisciplinary meetings meetings involving people from different professional backgrounds.

multiprofessional from different professional backgrounds, within and outside of healthcare (e.g. nurse, consultant, social worker) concerned with the care or welfare of people.

GMC100829-0310

clinical assistant usually GPs, employed and paid by a trust, largely on a part time basis, to provide medical support on hospital wards and other departments.

clinical governance refers to the quality of health care offered within an organisation.
The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." It's about making sure that health services have systems in place to provide patients with high standards of care.

clinical governance review a review of the policies, systems and processes used by an organisation to deliver high quality health care to patients. The review looks at the way these policies work in practice (a health check for a health organisation).

clinical oncologist a doctor who specialises in the treatment of cancer patients, particularly through the use of radiotherapy, but who may also use chemotherapy.

clinical risk management understanding the various levels of risk attached to each form of treatment and systematically taking steps to ensure that the risks are minimised.

clinician/clinical staff a fully trained health professional – doctor, nurse, therapist, technician etc.

clinical negligence scheme for trusts (CNST) an 'insurance' scheme for assessing a trust's arrangements to minimise clinical risk which can offset costs of insurance against claims of negligence. Successfully gaining CNST 'standards' (to level one, two, three) reduces the premium that the trust must pay.

Commission for Health Improvement (CHI) independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.

co-codamol a medicine consisting of paracetamol and codeine phosphate, used for the relief of mild to moderate pain.

community care health and social care provided by health care professionals, usually outside hospital and often in the patient's own homes.

community health council (CHC) a statutory body sometimes referred to as the patients' friend. CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.

consultant a fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care. (For training posts in medicine see specialist registrar, senior house officer and preregistration house officer.)

continence management The practice of promoting or sustaning the ability to control urination and defecation.

continuing care a long period of treatment for patients whose recovery will be limited.

defibrillator a piece of equipment which sends an electric current through the heart to restore the heart beat.

diamorphine A medicine used to relieve severe pain.

do not attempt resuscitation (DNAR) or do not resuscitate (DNR) an instruction, which says that if a patient's health suddenly deteriorates to near death, no special measures will be taken to revive their heart. This instruction should be agreed between the patient and doctor or if a patient is not conscious, then with their closest relative.

dysphagia difficulty swallowing.

fentanyl a medicine prescribed to patients who require control of existing pain.

finished consultant episode (FCE) a period of continuous consultant treatment under a specific consultant. If a patient is transferred from one consultant to another it will be counted as two FCEs.

formulary a list of preferred medicinal drugs which are routinely available in a hospital or GP surgery.

Acknowledgements

CHI wishes to thank the following people for their help and cooperation with the production of this report:

- the patients and relatives who contributed either in person, over the phone or in writing. CHI recognises how difficult some of these contacts were for the relatives of those who have died
- staff interviewed by CHI's investigation team (see appendix C) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millett, Chief Executive (until 31 March 2002) and Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust (since 1 April 2002)
- staff and patients who welcomed the CHI team on to the wards during observation work
- Detective Superintendent John James, Hampshire Constabulary
- the agencies listed in appendix D who gave their views and submitted relevant documents to the investigation

GMC100829-0311

Glossary

accountability responsibility, in the sense of being called to account for something.

action plan an agreed plan of action and timetable that makes improvements to services.

acute care/ trust/hospital short term (as opposed to chronic, which means long term).
Acute care refers to medical and surgical treatment involving doctors and other medical staff in a hospital setting.
Acute hospital refers to a hospital that provides surgery, investigations, operations, serious and other treatments, usually in a hospital setting.

allied health professionals professionals regulated by the Council for Professions Supplementary to Medicine (new Health Professions Council). This includes professions working in health, social care, education, housing and other sectors. The professions are art therapists, music therapists and drama therapists, prosthetists and orthotists, dieticians, orthoptists, occupational therapists, physiotherapists, biomedical scientists, speech and language therapists, radiographers, chiropodists and podiatrists, ambulance workers and clinical scientists. Also called professionals allied to or supplementary to medicine.

analgesia medicines prescribed to reduce pain.

anticipatory prescribing to prescribe a drug or other remedy in advance.

antipsychotics A group of medicines used to treat psychosis (conditions such as schizophrenia) and sometimes used to calm agitation. Examples include haloperidol. Also called major tranquillisers or neuroleptics.

appraisal an assessment or estimate of the worth, value or quality of a person or service or thing.

Association of Chief Police Officers (ACPO) an association whose members hold the rank of Chief Constable, deputy Chief Constable or Assistant Chief Constable or their equivalents. They provide a professional opinion to the Government and appropriate organisations.

audit, clinical audit an examination of records to check their accuracy. Often used to describe an examination of financial accounts in a business.
In clinical audit those involved in providing services assess the quality of care. Results of a process or intervention are assessed, compared with a preexisting standard, changed where necessary, and then reassessed.

Barthel score a validated tool used to measure physical disability.

benzodiazepines a diverse group of medicines used for a range of purposes. Some reduce anxiety, others are used as sleeping tablets. Some, such as *midazolam*, act as strong sedatives and can be accompanied by memory loss whilst the medicine is active.

British National Formulary publication that provides information on the selection and use of medicines for healthcare professionals.

carers people who look after their relatives and friends on an unpaid, voluntary basis often in place of paid care workers.

casemix the variety and range of different types of patients treated by a given health professional or team.

catheter a hollow tube passed into the bladder to remove urine.

catheterisation use of a catheter.

CHI see Commission for Health Improvement.

clinical any treatment provided by a healthcare professional. This will include, doctors, nurses, AHPs etc. Non clinical relates to management, administration, catering, portering etc.

GMC100829-0312

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	500mg	5	0	1	0	0
	Dryad	500mg	5	0	2	0	0
	Sultan	500mg	5	1	1	0	4
	Total			1	4	0	4
Haloperidol injection	Daedalus	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
	Sultan	5mg/5ml	10	43	15	6	0
	Total			44	19	6	0
Haloperidol injection	Daedalus	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
	Sultan	5mg/5ml	5	0	0	0	16
	Total			0	0	0	21
Midazolam	Daedalus	10mg/2ml	10	37	51	39	17
	Dryad	10mg/2ml	10	75	108	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total			133	168	116	47

(Source: Portsmouth Healthcare NHS Trust)

Dose: a single measured quantity of medicine

Pack: a collection of single doses, the packaging in which medicines are dispatched from the pharmacy

Executive summary

CHI has undertaken this investigation as a result of concerns expressed by the police and others around the care and treatment of frail older people provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001. CHI is grateful to the Hampshire Constabulary for sharing information with us which contributed towards the local and national recommendations CHI makes to improve the care of this vulnerable group of NHS patients.

CHI has conducted a detailed review of the systems in place to ensure good quality patient care. CHI does not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual.

Key conclusions

CHI concludes that a number of factors, detailed in the report, contributed to a failure of trust systems to ensure good quality patient care:

- there were insufficient local prescribing guidelines in place governing the prescription of powerful pain relieving and sedative medicines
- the lack of a rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for older people not being questioned
- the absence of adequate trust wide supervision and appraisal systems meant that poor prescribing practice was not identified
- there was a lack of thorough multidisciplinary total patient assessment to determine care needs on admission

CHI also concludes that the trust now has adequate policies and guidelines in place which are being adhered to governing the prescription and administration of pain relieving medicines to older patients.

GMC100829-0313

Key findings

National and local context (Chapter 3)

- Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team.
- 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.

Arrangements for the prescription, administration, review and recording of medicines (Chapter 4)

- 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.

Quality of care and the patient experience (Chapter 5)

- 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.
- Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

Staffing arrangements and responsibility for patient care (Chapter 6)

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff.

Breakdown of medication in Dryad, Sultan and Daedalus wards at Gosport War Memorial Hospital

Figure I.1 Summary of medicine usage 1997/1998–2000/2001 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total			6	10	0	19
Diamorphine via syringe driver	Sultan	5mg	1	0	10	0	0
	Total			0	10	0	0
Diamorphine injection	Daedalus	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	67	36	24	35
	Total			128	127	107	74
Diamorphine via syringe driver	Dryad	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total			0	37	0	0
Diamorphine injection	Daedalus	30mg	5	16	27	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	43	14	31
	Total			117	121	69	42
Diamorphine via syringe driver	Dryad	30mg	1	0	5	0	0
	Total			0	5	0	0
Diamorphine injection	Daedalus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total			34	51	3	33

GMC100829-0314

APPENDIX H

Patient throughput data 1997/1998 – 2000/2001

Figure H.1 Throughput data 1997/1998 – 2000/2001

Financial year	Ward	Finished consultant episodes
1997/1998	Daedalus	97
1997/1998	Dryad	72
1997/1998	Sultan	287
	Total	456
1998/1999	Daedalus	121
1998/1999	Dryad	76
1998/1999	Sultan	306
	Total	503
1999/2000	Daedalus	110
1999/2000	Dryad	131
1999/2000	Sultan	402
	Total	643
2000/2001	Daedalus	113
2000/2001	Dryad	86
2000/2001	Sultan	380
	Total	579

(Source: 1997/1998 – trust ward based discharge data, 1998/1999, 1999/2000 and 2000/2001 – trust patient administration system (PAS) data).

Lessons learnt from complaints (Chapter 7)

- The police investigation, the review of the Health 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.

Clinical governance (Chapter 8)

- The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

Recommendations

It is clear from a number of CHI recommendations to the Fareham and Gosport Primary Care Trust (PCT) and the East Hampshire PCT, that continued close and effective working relationships between both PCTs will be essential in order to implement the recommendations in this report. CHI is aware of the high level of interdependence that already exists between these two organisations and urges that this continues.
CHI is aware that many of these recommendations will be relevant to emerging PCTs and urges all PCTs to take action where appropriate.

Fareham and Gosport/ East Hampshire Primary Care Trust

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

3. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

4. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

GMC100829-0315

5. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

6. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

7. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

8. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

9. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

10. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

11. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

12. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

13. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

14. The Fareham and Gosport PCT and the East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

15. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

16. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangements, clinical governance responsibilities and training needs.

APPENDIX G

An explanation of the dissolution of services into the new primary care trusts

Figure G.1 Arrangements for hosting clinical services

Department	Portsmouth City PCT	East Hampshire PCT	Fareham & Gosport PCT	West Hampshire NHS Trust
Elderly medicine		•		
Elderly mental health		•		
Community paediatrics	•			
Adult mental health services	• For Portsmouth patients			• For Hampshire patients
Learning disability services			•	
Substance misuse	•			
Clinical pyschology	•			
Primary care counselling				•
Specialist family planning	•			
Palliative care		•		

(Source: *Local health, local decisions*, consultation document, September 2001, NHS Executive South East Regional Office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

GMC100829-0316

Elderly medicine consultant input and access to specialist advice

Patients on Daedalus and Dryad wards received regular, documented review by consultant staff. There was clear evidence of specialist input, from mental health physicians, therapists and medical staff from the acute sector.

Out of hours cover

There was little evidence of out of hours input into the care of patients reviewed by CHI, though the team formed the view that this had been appropriate and would indicate that the general management of patients during regular hours was therefore of a good standard.

17. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

18. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

19. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

20. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

21. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

22. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

Hampshire and Isle of Wight Strategic Health Authority

23. Hampshire and Isle of Wight Strategic Health Authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

Department of Health

24. The Department of Health should assist in the promotion of an NHS wide understanding of the various terms used to describe levels of care for older people.

25. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

GMC100829-0317

Appropriate administration of medicines by nursing staff was evident. Prescriptions issued over the telephone by GPs on Sultan ward were appropriately completed in accordance with trust policy.

Review and recording of medicines

Evidence of consistent review of medication was seen, with evidence to suggest that patients and relatives were involved in helping to determine levels of pain. Nursing staff had appropriately administered medicines in line with medical staff prescriptions. Prescription sheets had been completed adequately on all three wards. Generally, record keeping around prescribing was clear and consistent, though this was not as clear on Sultan ward.

Based on the medical notes reviewed, the group agreed that the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs were being adhered to.

(ii) *Quality of nursing care towards the end of life*

The team found a consistently reasonable standard of care given to all patients they reviewed. The quality of nursing notes was generally adequate, although not always of consistent quality. There was some evidence to suggest a task oriented approach to care with an over emphasis on the completion of paperwork. This left an impression of a sometimes disjointed rather than integrated individual holistic assessment of the patient. The team saw some very good, detailed care plans and as well as a number of incidences where no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphagia had been delayed over a weekend because of the lack of availability of suitably trained nursing staff. Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, the trust's policies regarding fluid and nutrition were generally being adhered to. Though based on the nursing notes, a number of patients had only been weighed once, on admission.

There was evidence of therapy input, but this had not always been incorporated into care plans and did not always appear comprehensive. There was some concern that despite patients being assessed as at risk of pressure sores, it was not clear how this had been managed for some patients.

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. Do not attempt resuscitation decisions were clearly stated in the medical records.

Recorded cause of death

The group found no cause for concerns regarding any of the stated causes of death.

GENERAL COMMENTS

Admission criteria

The team considered that the admission criteria for Daedalus and Dryad wards was being adhered to. However there were examples of patients admitted to Sultan ward who were more dependent than the admission criteria stipulates. There is also an issue regarding patients who initially meet the admission criteria for Sultan ward who then develop complications and become more acutely sick.

GMC100829-0318

APPENDIX F

Report of the Gosport investigation medical notes review group

PURPOSE

CHI undertook a review of the anonymised medical notes of a random selection of 15 patients who had died between 1 August 2001 and 31 January 2002 on Daedalus, Dryad or Sultan wards at Gosport War Memorial Hospital.

CHI's intention for this piece of work was to determine whether the policies and systems put in place by the Portsmouth Healthcare NHS Trust since the events of 1998, to address prescribing practices are being implemented and are impacting on the quality of care patients are now receiving. CHI's review also considered the nursing notes for each patient and looked at the quality of nursing care as documented in the notes. Finally, the review considered whether the cause of death recorded in the notes was appropriate.

METHODOLOGY

The group received 15 sets of anonymised medical notes from the trust, which related to the last admission of 15 patients. Five patients were randomly selected from each of the following wards: Daedalus, Dryad and Sultan. A total of 49 patients had died whilst on these wards during the sample timeframe.

FINDINGS

(i) *Use of medicines*

Prescription

The group considered that the volume and combination of medicines used was appropriate for this group of patients and was in line with accepted good practice and British National Formulary guidelines. Single prescription, PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the trust's 'analgesic ladder' to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggest that patients had been prescribed large amounts of pain relief, such as diamorphine on admission where this was not necessary. Co-codamol had been prescribed in a number of cases as an initial analgesic, with progression to alternative medicines as and when more pain relief was needed. The use of the analgesic ladder was less evident in Sultan ward.

However, in two cases, the group saw evidence of unacceptable breakthrough pain, and six hourly rather than four hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of co-codamol and fentanyl, which was not thought by the group to be the most effective combination of medicines.

Administration

Syringe drivers had been used to deliver medication to six of the patients reviewed. Appropriate use of syringe drivers as a method of medicine administration was observed, with documented discussions with families before use.

1 | Terms of reference and process of investigation

1.1 During the summer of 2001, concerns were raised with CHI about the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the Gosport War Memorial Hospital. These concerns were also about the responsibility for clinical care and transfer arrangements with other hospitals.

1.2 On 22 October 2001, CHI launched an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust was responsible at the Gosport War Memorial Hospital. CHI's decision was based on evidence of high risk activity and the likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

1.3 The investigation terms of reference were informed by a chronology of events provided by the trust surrounding the death of one patient. Discussions were also held with the trust, the Isle of Wight, Portsmouth and South East Hampshire Health Authority and the NHS south east regional office to ensure maximum learning locally and for the NHS.

1.4 The terms of reference agreed on 9 October 2001 are as follows:

The investigation will look at whether, since 1998, there had 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

GMC100829-0319

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.

CHI's investigation team

1.5 CHI's investigation team were:

- Alan Carpenter, Chief Executive, Somerset Coast Primary Care Trust
- Anne Grosskurth, CHI Support Investigations Manger
- Dr Tony Luxton, Consultant Geriatrician, Cambridge City Primary Care Trust
- Julie Miller, CHI Lead Investigations Manager
- Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
- Mary Parkinson, lay member (Age Concern)
- Jennifer Wenborn, Independent Occupational Therapist

1.6 The team was supported by:

- Liz Fradd, CHI Director of Nursing, lead CHI director for the investigation
- Nan Newberry, CHI Senior Analyst
- Ian Horrigan, CHI Analyst
- Kellie Rehill, CHI Investigations Coordinator
- a medical notes review group established by CHI to review anonymised medical notes (see appendix E)
- Dr Barry Tennison, CHI Public Health Adviser

The investigation process

1.7 The investigation consisted of five interrelated parts:

- review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (see appendix A for a list of documents reviewed)
- analysis of views received from 36 patients, relatives and friends about care received at Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls and a short questionnaire (see appendix B for an analysis of views received)

FINDINGS OF GROUP

The findings of the group will be shared with:

(i) the CHI Gosport investigation team

(ii) CHI's Nurse Director and Medical Director and other CHI staff as appropriate

(iii) the trust

(iv) relatives of the deceased (facilitated by the trust) if requested, on an individual basis

The final report of the group will be subject to the rules of disclosure applying to CHI investigation reports.

GMC100829-0320

APPENDIX E

Medical case note review team: terms of reference and membership

Terms of reference for the medical notes review group to support the CHI investigation at Gosport War Memorial Hospital

PURPOSE

The group has been established to review the clinical notes of a random selection of recently deceased older patients at the Gosport War Memorial Hospital in order to inform the CHI investigation. With reference to CHI's investigation terms of reference and the expert witness reports prepared for the police by Dr Munday and Professor Ford, this review will address the following:

(i) the prescription, administration, review and recording of drugs

(ii) the use and application of the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs

(iii) the quality of nursing care towards the end of life

(iv) the recorded cause of death

METHOD

The group will review 15 anonymised clinical notes supplied by the trust, followed by a one day meeting at CHI in order to produce a written report to inform the CHI investigation. The group will reach its conclusions by 31 March 2002 at the latest.

MEMBERSHIP

- Dr Tony Luxton, Geriatrician
  Cambridge City PCT
  (CHI doctor team member and chair of the group)
- Maureen Morgan, Independent Management Consultant
  (CHI nurse member)
- Professor Gary Ford, Professor of Pharmacology of Old Age
  University of Newcastle and Freeman Hospital
- Dr Keith Munday, Consultant Geriatrician
  Frimley Park Hospital
- Annette Goulden, Deputy Director of Nursing
  NHS Trent regional office and formerly
  Department of Health Nursing Officer for elderly care

- a five day visit by CHI's investigation team to Gosport War Memorial Hospital when a total of 59 staff from all groups involved in the care and treatment of older people at the hospital and trust managers were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards (see appendix C for a list of all staff interviewed)
- interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (see appendix D for a list of organisations interviewed)
- an independent review of anonymised clinical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendices E and F. CHI shared the summary with the Fareham & Gosport PCT in May 2002

GMC100629-0321

2 | Background to the investigation

Events surrounding the CHI investigation

Police investigations

2.1 A relative of a 91 year old patient who died in August 1998 on Daedalus ward made a complaint to the trust about her care and treatment. The police were contacted in September 1998 with allegations that this patient had been unlawfully killed. A range of issues were identified by the police in support of the allegation and expert advice sought. Following an investigation, documents were referred to the Crown Prosecution Service in November 1998 and again in February 1999. The Crown Prosecution Service responded formally in March 1999 indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.

2.2 Following further police investigation, in August 2001, the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

2.3 Local media coverage in March 2001 resulted in 11 other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate. Two expert reports were received in December 2001 which were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.

2.4 In February 2002, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the General Medical Council, the United Kingdom Central Council (after 1 April 2002, the Nursing and Midwifery Council), the trust, the Isle of Wight, Portsmouth and East Hampshire Health Authority and the NHS south east regional office.

2.5 The police made the trust aware of potential issues around diamorphine usage in December 1998, and were sent the expert witness reports in February 2002.

- Local representative for Unison

  Patrick Carroll, Branch Chair

- Local general practitioners

  Dr J Barton, Knapman Practice

  Dr P Beasley, Knapman Practice

  Dr S Brook, Knapman Practice

GMC100829-0322

- Portsmouth Social Services

  Sarah Mitchell, Assistant Director (Older People)

  Helen Loten, Commissioning and Development Manager

- Hampshire Social Services

  Tony Warns, Service Manager for Adults

- Alverstoke House Nursing and Residential Care Home

  Sister Rose Cook, Manager

- Glen Heathers Nursing and Residential Care Home

  John Perkins, Manager

Other

- League of Friends

  Mary Tyrell, Chair

  Geoff Rushton, Former Treasurer

- Motor Neurone Disease Association

  Mrs Fitzpatrick

- Members of Parliament

  Peter Viggers, MP for Gosport

  Sydney Rapson, MP for Portsmouth North

- Primary Care Groups

  John Kirtley, Chief Executive, Fareham and Gosport Primary Care Groups

  Dr Pennells, Chairperson, Gosport Primary Care Groups

- Portsmouth Local Medical Committee

  Dr Stephen McKenning, Chairman

- Gosport War Memorial Hospital medical committee

  Dr Warner, Chairman

- Local representative for the Royal College of Nursing

  Betty Woodland, Steward

  Steve Barnes, RCN Officer

Action taken by professional regulatory bodies

2.6 The General Medical Council is currently reviewing whether any action against any individual doctor is warranted under its fitness to practice procedures.

2.7 The Nursing and Midwifery Council are considering whether there are any issues of professional misconduct in relation to any of the nurses referred to in police documentation.

Complaints to the trust

2.8 There have been 10 complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and December 1998 raised concerns which included pain management, the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which triggered the initial police investigation. This complaint was not pursued through the NHS complaints procedure.

Action taken by the health authority

2.9 In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people in 1998 and, secondly, as the body through which GPs were permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered by GPs on hospital premises.

2.10 In June 2001, the health authority voluntary local procedure for the identification and support of primary care medical practitioners whose practice is giving cause for concern reviewed the prescribing practice of one local GP. No concerns were found. This was communicated to the trust.

2.11 In July 2001, the chief executive of the health authority asked CHI for advice in obtaining a source of expertise in order to reestablish public confidence in the services for older people in Gosport. This was at the same time as the police contacted CHI.

2.12 Following receipt of the police expert witness reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers and sedatives (opiates and benzodiazepines) in general practice.

GMC100829-0323

Action taken by the NHS south east regional office

2.13 For the period of the investigation, the NHS regional offices were responsible for the strategic and performance management of the NHS, including trusts and health authorities. The NHS south east regional office had information available expressing concerns around prescribing levels at the Gosport War Memorial Hospital. Information included a report by the Health Service Ombudsman and serious untoward incident reports forwarded by the trust in April and July 2001 in response to media articles about the death of a patient at the Gosport War Memorial Hospital.
The health authority and NHS south east regional office met to discuss these issues on 6 April 2001.

APPENDIX D

Meetings or telephone interviews with external agencies with an involvement in elderly care at Gosport War Memorial Hospital

- **Portsmouth Hospitals NHS Trust**

  Jill Angus, Clinical Discharge Coordinator

  Wendy Peckham, Discharge Planner for Medicine

  Clare Bownass, Ward Sister

  Sonia Baryschpolec, Staff Nurse

  Sam Page, Bed Manager, Royal Haslar Hospital

  Sally Clark, Patient Transport Manager

  Julie Sprack, Senior Nurse

  Jeff Watling, Chief Pharmacist

  Vanessa Lawrence, Pharmacist

- **Hampshire Ambulance Service NHS Trust**

  Alan Lyford, Patient Transport Service Manager

- **Isle of Wight, Portsmouth & South East Hampshire Health Authority**

  Penny Humphris, Chief Executive

  Dr Peter Old, Director of Public Health

  Nicky Pendleton, Progamme Lead for Elderly Care Services

- **NHS Executive south east regional office**

  Dr Mike Gill, Regional Director of Public Health

  Dr David Percy, Director of Education and Training

  Harriet Boereboom, Performance Manager

- **Portsmouth and South East Hampshire Community Health Council**

  Joyce Knight, Chairman

  Christine Wilkes, Vice Chair

  Margaret Lovell, Chief Officer

- **Hampshire Constabulary**

  Detective Superintendent John James

GMC100829-0324

- Lee, D, Complaints Convenor & Non Executive Director
- Lock, J, Sister (retired 1999)
- Loney, M, Porter
- Lord, Dr A, Lead Consultant
- Mann, K, Senior Staff Nurse
- Melrose, B, Project Manager – Complaints
- Millett, M, Chief Executive (until 31 March 2002)
- Monk, A, Chairman
- Nelson, S, Staff Nurse
- Neville, J, Staff Nurse (until 1 January 2001)
- O'Dell, J, Practice Development Facilitator
- Parvin, J, Senior Personnel Manager
- Peach, J, Service Manager
- Peagram, L, Physiotherapy Assistant
- Pease, Y, Staff Nurse
- Phillips, C, Speech & Language Therapist
- Piper, I, Operational Director
- Qureshi, Dr L, Consultant
- Ravindrance, Dr A, Consultant
- Reid, Dr I, Medical Director
- Robinson, B, Deputy General Manager
- Scammel, T, Senior Nurse Coordinator
- Taylor, J, Senior Nurse
- Thomas, Dr E, Nursing Director
- Thorpe, M, Health Care Support Worker
- Tubbitt, A, Senior Staff Nurse
- Walker, F, Senior Staff Nurse
- Wells, P, District Nurse
- Wigfall, M, Enrolled Nurse
- Wilkins, P, Senior Staff Nurse
- Williams, J, Nurse Consultant
- Wilson, A, Senior Staff Nurse
- Wood, A, Finance Director
- Woods, L, Staff Nurse
- Yikona, Dr J, Staff Grade Physician

CHI is grateful to Caroline Harrington for scheduling interviews.

3 | National and local context

National context

3.1 The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS Plan and the Standing Nursing and Midwifery Committee's 2001 annual report found aspects of care to be deficient. National concerns raised include: an inadequate and demoralised workforce, poor care environments, lack of seamless care within the NHS and ageism. The NHS Plan's section *Dignity, security and independence in old age*, published in July 2000, outlined the government's plans for the care of older people, detailed in the national service framework.

3.2 The national service framework for older people was published in March 2001 and sets standards of care for older people in all care settings. It aims to ensure high quality of care and treatment, regardless of age. Older people are to be treated as individuals with dignity and respect. The framework places special emphasis on the involvement of older patients and their relatives in the care process, including care planning.

3.3 National standards called *Essence of Care*, published by the Department of Health in 2001, provide standards for assessing nursing practice against fundamental aspects of care such as nutrition, preventing pressure sores and privacy and dignity. These are designed to act as an audit tool to ensure good practice and have been widely disseminated across the NHS.

Trust background

3.4 Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust between April 1994 and April 2002. The hospital is situated on the Gosport peninsula and has 113 beds. Together with outpatient services and a day hospital, there are beds for older people and maternity services. The hospital does not admit patients who are acutely ill and it has neither an A&E nor intensive care facilities. Portsmouth Healthcare NHS Trust provided a range of community and hospital based services for the people of Portsmouth, Fareham, Gosport and surrounding areas. These services included mental health (adult and elderly), community paediatrics, elderly medicine, learning disabilities and psychology.

3.5 The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/2002 the trust had a budget in excess of £100 million and over 20% of income spent on its largest service, elderly medicine. All the trust's financial targets were met in 2000/2001.

GMC100829-0325

Move towards the primary care trust

3.6 Portsmouth Healthcare NHS Trust was dissolved on 31 March 2002. Services have been transferred to local primary care trusts (PCTs), including Fareham and Gosport PCT, which became operational as a level four PCT in April 2002. Arrangements have been made for each PCT to host provider services on a district wide basis but each PCT retains responsibility for commissioning its share of district wide services from the host PCT. Fareham and Gosport PCT will manage many of the staff, premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Medical staff involved in the care of older people, including those working at the Gosport War Memorial Hospital, are now employed by the East Hampshire PCT.

Portsmouth Healthcare NHS Trust strategic management

3.7 The trust board consisted of a chair, five non executive directors, the chief executive, the executive directors of operations, medicine, nursing and finance and the personnel director. The trust was organised into six divisions, two of which are relevant to this investigation. The Fareham and Gosport division, which managed the Gosport War Memorial Hospital, and the department of medicine for elderly people.

3.8 CHI heard that the trust was well regarded in the local health community and had developed constructive links with the health authority and local primary care groups (PCGs). For example, in the lead up to the formation of the new PCT, Portsmouth Healthcare NHS Trust's director of operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the trust on the development of intermediate care and clinical governance. High regard and respect for trust staff was also commented on by the local medical committee, Unison and the Royal College of Nursing.

Local services for older people

3.9 Before April 2002, access to medical beds for older people in Portsmouth (which included acute care, rehabilitation and continuing care) was managed through the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. Some of the beds were located in community hospitals such as the Gosport War Memorial Hospital, where the day to day general management of the hospital was the responsibility of the locality divisions of Portsmouth Healthcare NHS Trust. The Fareham and Gosport division of the trust fulfilled this role at the Gosport War Memorial Hospital.

3.10 The department of medicine for elderly people has now transferred to East Hampshire PCT. The nursing staff of the wards caring for older people at the Gosport War Memorial Hospital are now employed by the Fareham and Gosport PCT. Management of all services for older people has now transferred to the East Hampshire PCT. •

3.11 General acute services were, and remain, based at Queen Alexandra and St Mary's hospitals, part of the Portsmouth Hospitals NHS Trust, the local acute trust. Though an unusual arrangement, a precedent for this model of care existed, for example in Southampton Community NHS Trust.

APPENDIX C

Portsmouth Healthcare NHS Trust staff and non executive directors interviewed by CHI

- Baldacchino, L, Health Care Support Worker
- Banks, Dr V, Lead Consultant
- Barker, D, Staff Nurse
- Barker, M, Enrolled Nurse
- Barrett, L, Staff Nurse
- Beed, P, Clinical Manager
- Brind, S, Occupational Therapist
- Cameron, F, General Manager
- Carroll, P, Occupational Therapist
- Clasby, J, Senior Nurse
- Crane, R, Senior Dietician
- Day, G, Senior Staff Nurse
- Douglas, T, Staff Nurse
- Dunleavy, J, Staff Nurse
- Dunleavy, S, Physiotherapist
- Goode, P, Health Care Support Worker
- Hair, Revd J, Chaplain
- Hallman, S, Senior Staff Nurse (until 11 September 2000)
- Hamblin, G, Senior Staff Nurse
- Haste, A, Clinical Manager
- Hooper, B, Project Director
- Humphrey, L, Quality Manager
- Hunt, D, Staff Nurse (until 6 January 2002)
- Jarrett, Dr D, Lead Consultant
- Joice, C, Staff Nurse (until 4 October 1999)
- Jones, J, Corporate Risk Advisor
- Jones, T, Ward Clerk
- King, P, Personnel Director
- King, S, Clinical Risk Advisor
- Landy, S, Senior Staff Nurse
- Langdale, H, Health Care Support Worker
- Law, D, Patient Affairs Manager

GMC100829-0326

v. Patient transfer. Contacts commented on the state of the patient's health before and during the transfer. Other stakeholders mentioned the time that it took to transfer the patient and also highlighted the inappropriate method of transporting the patient.

vi. Nutrition and fluids. Stakeholders highlighted a lack of help in feeding patients. They commented on how dehydrated the patients appeared and the lack of positive communication between the relative/carer and the staff to overcome the relative/carer's concern about the level of nutrition and fluids.

vii. Humanity of care.

- incontinence management – stakeholders felt that there was limited help with patients that needed to use the toilet
- attitude of staff – stakeholders commented on staff attitude, mentioning the length of time it took for staff to respond. Other comments related to the basic lack of care for patients in their last few days
- provision of bells – stakeholders observed that the bells were often out of the patients reach
- management of clothing – stakeholders commented that the patients were never in their own clothes

viii. Arrangements for the prescription, administration, review and recording of medicines. The majority of concerns were around the prescribing of diamorphine. Others centred on those authorised to prescribe the medication to the patient and how this was communicated to the relatives/carer.

ix. Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations. Interviewees indicated a lack of staff contact with the relatives/carers about the condition of the patient and the patient's care plan. Other interviewees commented on how some of the staff were not approachable. One interviewee referred to the absence of lay terms to describe a patient's condition, making it difficult to understand the patient's status of health.

x. Arrangements to support patients and their relatives and carers towards the end of the patient's life. Stakeholders mainly thought that there was a lack of communication from the staff after their relative had died.

xi. Three of the contacts had made complaints to the trust through the NHS complaints procedure. All were dissatisfied about the trust response.

3.12 Until August 2001, the Royal Hospital Haslar, a Ministry of Defence military hospital on the Gosport peninsula, also provided acute medical care to civilians, many of whom were older people, as well as military staff.

Service performance management

3.13 Divisional management at Portsmouth Healthcare NHS Trust was well defined, with clear systems for reporting and monitoring. The quarterly divisional review was the principal tool for the performance management of the Fareham and Gosport division. The review considered regular reports on clinical governance, complaints and risk. Fareham and Gosport division was led by a general manager, who reported to the operational director. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level.

Inpatient services for older people at the Gosport War Memorial Hospital 1998-2002

3.14 Gosport War Memorial Hospital provides continuing care, rehabilitation, day hospital and outpatient services for older people and was managed by the Fareham and Gosport division. In November 2000, as a result of local developments to develop intermediate and rehabilitation services in the community, there was a change in the use of beds at the hospital to provide additional rehabilitation beds.

3.15 In 1998, three wards at Gosport War Memorial Hospital admitted older patients for general medical care: Dryad, Daedalus and Sultan. This is still the case in 2002.

Figure 3.1 Inpatient provision at Gosport War Memorial Hospital by ward

Ward	1998	2002
Dryad	20 continuing care beds. Patients admitted under the care of a consultant, with some day to day care provided by a clinical assistant.	20 continuing care beds for frail elderly patients and slow stream rehabilitation. Patients admitted under the care of a consultant. Day to day care is provided by a staff grade doctor.
Daedalus	16 continuing care beds and 8 for slow stream rehabilitation. Patients admitted under the care of a consultant, some day to day care provided by a clinical assistant.	24 rehabilitation beds: 8 general, 8 fast and 8 slow stream (since November 2000). Patients admitted under the care of a consultant. Day to day care provided by a staff grade doctor.
Sultan	24 GP beds with care managed by patients' own GPs. Patients were not exclusively older patients; care could include rehabilitation and respite care. A ward manager (or sister) managed the ward, which was staffed by Portsmouth Healthcare NHS Trust staff.	The situation is the same as in 1998, except that the nursing staff are now employed by Fareham and Gosport PCT.

GMC100829-0327

Admission criteria

3.13 The current criteria for admission to both Dryad and Daedalus wards are that the patient must be over 65 and be registered with a GP within the Gosport PCG (now a part of Fareham and Gosport PCT). In addition, Dryad patients must have a Barthel score of under 4/20 and require specialist medical and nursing intervention. The Barthel score is a validated tool used to measure physical disability. Daedalus patients must need multidisciplinary rehabilitation, for example following a stroke.

3.14 There was, and still is, a comprehensive list of admission criteria for Sultan ward developed in 1999, all of which must be met prior to admission. The criteria state that patients must not be medically unstable and no intravenous lines must be in situ.

Elderly mental health

3.15 Although not part of the CHI investigation, older patients are also cared for on Mulberry ward, a 40 bed assessment unit comprising Collingwood and Ark Royal wards. Patients admitted to this ward are under the care of a consultant in elderly mental health.

Terminology

3.16 CHI found considerable confusion about the terminology describing the various levels of care for older people in written information and in interviews with staff. For example, the terms stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care were all used. CHI was not aware of any common local definition for these terms in use at the trust or of any national definitions. CHI stakeholder work confirmed that this confusion extended to patients and relatives in terms of their expectations of the type of care received.

KEY FINDINGS

1. Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team. The chief executive was accessible to and well regarded by staff both within the trust and in the local health economy. Good links had been developed with local PCGs.

2. The case note review undertaken by CHI confirmed that the admission criteria for both Dryad and Daedalus wards were being adhered to over recent months and that patients were being appropriately admitted. However, CHI found examples of some recent patients who had been admitted to Sultan ward with more complex needs than stipulated in the admission criteria that may have compromised patient care.

3. 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 that had not been fulfilled.

Figure B.1 Concerns about care raised by stakeholders by ward and date

	Dryad	Daedalus	Sultan	GWMH	TOTAL
1998		8		2	10
1999	1	5			6
2000		3	3	1	7
2001		1		1	2
GWMH				2	2
TOTAL	1	17	3	6	27

GWMH – Gosport War Memorial Hospital

ANALYSIS OF VIEWS RECEIVED

i. During the CHI investigation stakeholder views highlighted both positive and less positive experiences of patient care.

Positive experiences

ii. CHI received nine letters from stakeholders commenting on the satisfaction of the care that the patients received and highlighting the excellent level of care and kindness demonstrated by the staff. This was also supported by 400 letters of thanks and donations received by the Gosport War Memorial Hospital. The most frequently recurring positive comments from stakeholders were about staff attitude (five responses) and the environment (five responses). Other positive feedback was received about access to services, transfer, prescribing, end of life arrangements, communication and complaints.

iii. The overall analysis of the stakeholder comments indicated that staff attitude and the environment were most highly commended. Examples of staff attitude included comments such as, "one lovely nurse on Dryad went to say hello to every patient even before she got her coat off" and "as a whole the ward was lovely and there was no complaints against the staff". The environment was described as being tidy and clean with good decor. Another comment recognised the ward's attention to maintaining patient dignity with curtains been drawn reducing attention to the patient. One stakeholder commented on the positive experience they had when dealing with the trust concerning a complaint they had made.

Less positive experiences

iv. A number of less positive experiences of patients/friends and relatives were shared with CHI by stakeholders. The following table outlines the most frequently recurring negative comments that corresponded with CHI's terms of reference.

Figure B.2 Less positive views of patient and relative/friend experiences

View	Frequency of responses
Communication with relatives/carers/friends	14
Patient transfer	10
Nutrition and fluids	11
Prescription of medicines	9
Continence management, catheritisation	8
Staff attitude	8
End of life communication with:	
patients	4
relatives/carers/friends	6
Humanity of care ie access to buzzer, clothing	8

GMC100829-0328

APPENDIX B

Views from patients and relatives/friends

METHODS OF OBTAINING VIEWS

i. The investigation sought to establish the views of people who had experience of services for older people at the Gosport War Memorial Hospital since 1998.

ii. CHI sought to obtain views about the service through a range of methods. People were invited to:

- meet with members of the investigation team
- fill in a short questionnaire
- write to the investigation team
- contact by telephone or email

iii. In November 2001, information was distributed about the CHI investigation at Gosport War Memorial Hospital to stakeholders, voluntary organisations and statutory stakeholders. This information included posters advertising stakeholder events, information leaflets about the investigation, questionnaires and general CHI information leaflets. Press releases were issued in local newspapers and radio stations. The Hampshire Constabulary agreed to forward CHI contact details to families who had previously expressed their concerns to them.

iv. The written information was distributed to a large group of potential stakeholders. In total 36 stakeholders and 59 voluntary organisations will have received the above information. These people included:

- Motor Neurone Disease Association, Alzheimer's Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- Portsmouth and South East Hampshire Community Health Council, Isle of Wight, Portsmouth and South East Hampshire Health Authority, local medical committee, members of parliament, nursing homes, Portsmouth social services and Fareham and Gosport primary care groups

STAKEHOLDER RESPONSES

i. CHI received the following responses from patients, relatives, carers, friends and voluntary organisations.

Letters	Questionnaires	Telephone interviews	*Stakeholder interviews
7	2	10	17

(*stakeholders were counted according to the number of attendees and not based on number of interviews)

ii. A number of people who contacted CHI did so using more than one method. In these cases any other form of submitted evidence, was incorporated as part of the stakeholders contact.

RECOMMENDATIONS

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Hampshire and Isle of Wight strategic health authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

3. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

4. The Department of Health should assist in the promotion of an NHS wide shared understanding of the various terms used to describe levels of care for older people.

GMC100829-0329

4 | Arrangements for the prescription, administration, review and recording of medicines

Police inquiry and expert witness reports

4.1 CHI's terms of reference for its investigation in part reflected those of the earlier preliminary inquiry by the police, whose reports were made available to CHI.

4.2 Police expert witnesses reviewed the care of five patients who died in 1998 and made general comments in the reports about the systems in place at the trust to ensure effective clinical leadership and patient management on the wards. The experts' examination of the use of medicines in Daedalus, Dryad and Sultan wards led to significant concern about three medicines, the amounts which had been prescribed, the combinations in which they were used and the method of their delivery. In summary:

- there was no evidence of trust policy to ensure the appropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain. It was the view of the police expert witnesses that a more reasonable response would have been the prescription of mild to moderate medicine initially with appropriate review in the event of further pain followed up
- there was inappropriate combined subcutaneous administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death
- there were no clear guidelines available to staff to prevent assumptions being made by clinical staff that patients had been admitted for palliative, rather than rehabilitative care
- there was a failure to recognise potential adverse effects of prescribed medicines by clinical staff
- clinical managers failed to routinely monitor and supervise care on the ward

It is important to emphasise that these reports were not produced for this CHI investigation and CHI cannot take any responsibility for their accuracy. Whilst the reports provided CHI with very useful information, CHI has relied on its own independent scrutiny of data and information gathered during the investigation to reach the conclusions in this chapter.

64. March 2001 Final monitoring report intermediate care, Portsmouth Healthcare NHS Trust, May 2001

D) DOCUMENTS RELATING TO HAMPSHIRE CONSTABULARY INVESTIGATIONS

1. Police expert witness report, Professor B Livesley, MD, FRCP, 9 November 2000
2. Police expert witness report, Professor G Ford, MA, FRCP, 12 December 2001
3. Police expert witness report, Dr K Mundy, FRCP, 18 October 2001

E) OTHER DOCUMENTS RELATING TO GOSPORT WAR MEMORIAL HOSPITAL

1. A local procedure for the identification and support of primary care medical practitioners whose performance is giving cause for concern, Isle of Wight, Portsmouth and South East Hampshire Health Authority and local medical committee, undated
2. Clinical governance and clinical quality assurance, the baseline assessment framework, NHS Executive south east region, 1999
3. Clinical Governance, Audit 1998/1999 & Summary report, District Audit, December 1999

GMC100829-0330

45. District audit review of rehabilitation service for older people 2000/2001, Portsmouth Healthcare NHS Trust, January 2001

46. Memorandum to all medical staff re: rapid tranquillisation and attached protocol – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 23 February 2001

47. Correspondence re: guidelines on management of acute confusion from general manager – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 18 October 2001

48. Memorandum to all consultants from consultant geriatrician re: management of acute confusion elderly medicine, Queen Alexandra Hospital Portsmouth Healthcare NHS Trust, 30 April 2001

49. Community hospitals: guidelines for confirmation of death, Portsmouth Healthcare NHS Trust, policy date May 1998, review date May 1999

50. Memorandum: Guidelines for admission to Daedalus and Dryad ward, Portsmouth Healthcare NHS Trust, 4 October 2000

51. Clinical policy, admission and discharge policy, Portsmouth Healthcare NHS Trust, September 2000

52. Urgent notice for all medical and nursing staff in the event of a suspected fracture and/or dislocation of a patient on the above ward, Daedalus and Dryad wards, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 16 November 2001

53. Procedure for the initial management of medical emergencies in Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 15 January 2001

54. Audit of neuroleptic prescribing in elderly medicine, Portsmouth Healthcare NHS Trust, January-November 1999, November 1998-July 1999, September–December 2001

55. Administration of medicines, community hospitals – programme for updating qualified staff, Portsmouth Healthcare NHS Trust, 13 March 1997

56. Memorandum re: seminar – osteoporosis and falls, 14 November 2001, clinical assistant teaching elderly medicine, Portsmouth Healthcare NHS Trust, 19 October 2001

57. Introduction to Gosport War Memorial Hospital for staff, Portsmouth Healthcare NHS Trust, undated

58. Competence record and development for qualified nurses 1998-2001, Sultan, Dryad and Daedalus wards

59. Fareham and Gosport induction programme, 9 November 2001, Portsmouth Healthcare NHS Trust, undated

60. Training and development in community hospitals workshops – practice development facilitators (Gosport War Memorial Hospital, St Christophers Hospital, Emsworth Victoria Cottage Hospital, Petersfield Community Hospital, Havant War Memorial Hospital), East Hampshire Primary Care Trust, undated

61. Occupational therapy service – continuous professional development and training, Fareham and Gosport locality, occupational therapy professional advisor, 23 November 2001

62. Analysis of complaints at Gosport War Memorial Hospital, workshop notes and action plans, February 2001

63. Fareham and Gosport Primary Care Groups: Proposal to establish a primary care trust for Fareham and Gosport, Isle of Wight, Portsmouth and South East Hampshire Health Authority, July 2001

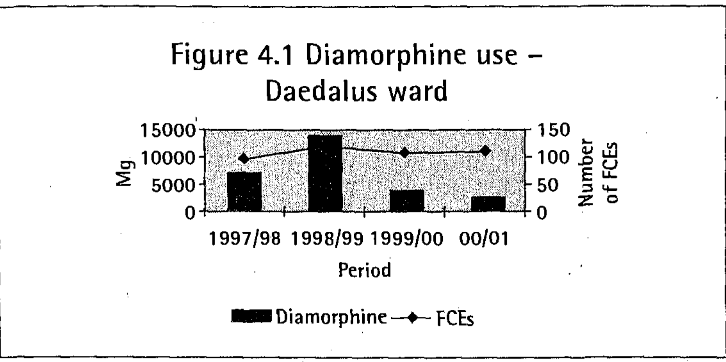
Medicine usage

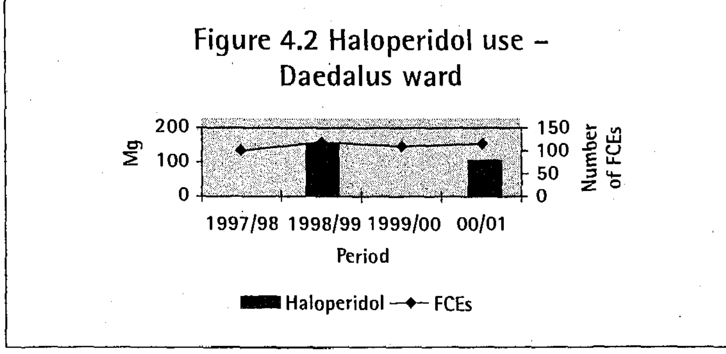
4.3 In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines issued from the pharmacy and does not include any wastage, nor can it verify the quantity of medicines administered to each patient. As the data does not offer any breakdown of casemix, it is not possible to determine how complex the needs of patients were in each year. Staff speaking to CHI described an increase in the numbers of sicker patients in recent years. A detailed breakdown of medicines issued to each ward is attached at appendix I.

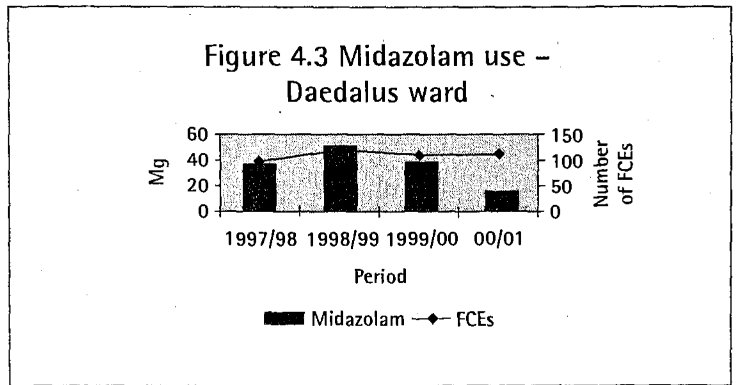
4.4 The experts commissioned by the police had serious concerns about the level of use of these three medicines (diamorphine, haloperidol and midazolam) and the apparent practice of anticipatory prescribing. CHI shares this view and believes the use and combination of medicines used in 1998 was excessive and outside normal practice. The following figures indicate the use of each medicine by ward and year, plotted alongside the number patients treated (finished consultant episodes).

4.5 The trust's own data, provided to CHI during the site visit week, illustrates a marked decline in the usage of diamorphine, haloperidol and midazolam in recent years. This decline has been most pronounced on Dryad ward and is against a rise in FCEs during the same timeframe. The trust's data demonstrates that usage of each of these medicines peaked in 1998/99. On Sultan ward, the use of haloperidol and midazolam have also declined in recent years with a steady increase in FCEs. Diamorphine use, after declining dramatically in 1999/00, showed an increase in 2000/01.

Medicine issued 1997/1998-2000/2001 according to the number of finished consultant episodes per ward, based on information provided by the Portsmouth Healthcare NHS Trust (see appendices H and I)







22. One year on: aspects of clinical nursing governance in the department of elderly medicine, Portsmouth Healthcare NHS Trust, September 2001

23. Operational policy, bank/overtime/agency, Fareham and Gosport community hospitals and elderly mental health, Portsmouth Healthcare NHS Trust, 1 May 2001

24. Job description: full time staff grade physician, Gosport War Memorial Hospital department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 5 July 2000

25. Correspondence re: staff grade physician contract – Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 26 September 2001

26. Correspondence re: consultant in medicine for the elderly contract, Wessex Regional Health Authority, 28 January 1992

27. Essential information for medical staff department of medicine for elderly people, Portsmouth Healthcare NHS Trust, undated

28. Department of medicine for elderly people, consultant timetables August 1997-November 2001, Portsmouth Healthcare NHS Trust

29. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated

30. Information for supervision arrangements for Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, November 2001

31. Clinical managers meeting minutes, Portsmouth Healthcare NHS Trust, 12 November 2001

32. Notes of action learning meeting, Portsmouth Healthcare NHS Trust, 11 June 2001

33. Notes from team leader meetings for the Daedalus ward, Portsmouth Healthcare NHS Trust, 5 April 2001

34. Notes of Daedalus ward meeting, Portsmouth Healthcare NHS Trust, 6 August 2001

35. Fareham & Gosport locality division, nursing accountability pathway, Portsmouth Healthcare NHS Trust, 25 October 2001

36. Medical accountability structure for Gosport War Memorial Hospital, undated

37. Supervision arrangement consultant timetable at Gosport War Memorial Hospital 1998-2001, Portsmouth Healthcare NHS Trust

38. Night skill mix review Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 28 March 2001

39. Vacancy levels 1998-2001 for Sultan, Daedalus and Dryad, Portsmouth Healthcare NHS Trust, 21 November 2001

40. Sickness absence statistics for Daedalus Ward, Gosport War Memorial Hospital, 2000-2001, undated

41. Sickness absence statistics for Sultan Ward, Gosport War Memorial Hospital, 1998-2001, undated

42. Wastage for qualified nurses – Daedalus, Dryad and Sultan Ward, undated

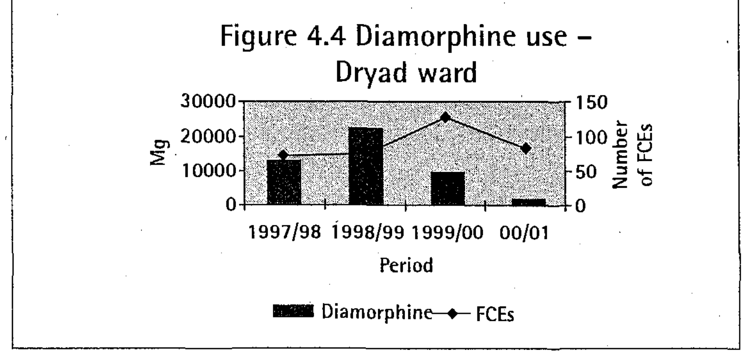
43. Winter escalation plans elderly medicine and community hospitals, Portsmouth Healthcare NHS Trust, undated

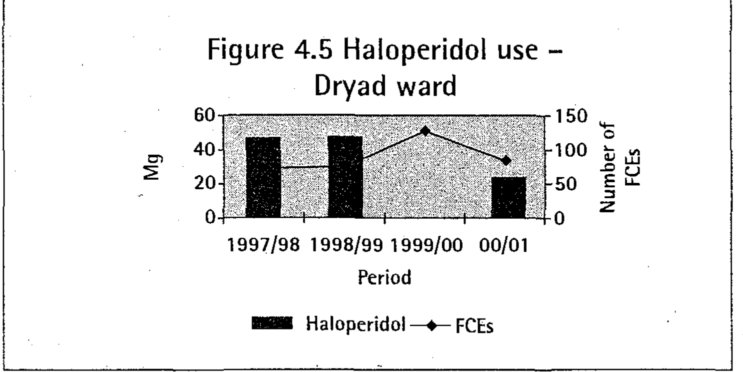
44. Audit of detection of depression in elderly rehabilitation patients, January-November 1998, Portsmouth Healthcare NHS Trust, undated

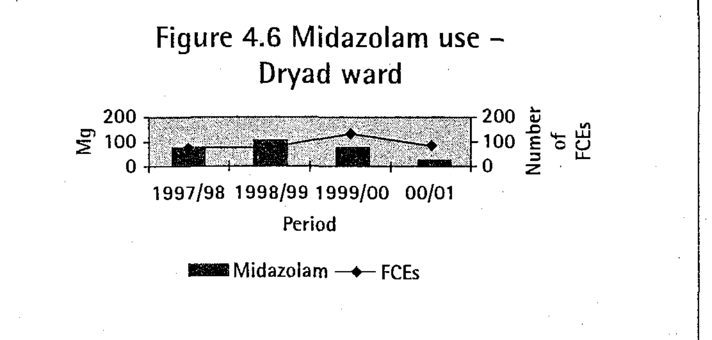
GMC100829-0332

C) DOCUMENTS RELATING TO THE DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE AT THE GOSPORT WAR MEMORIAL HOSPITAL

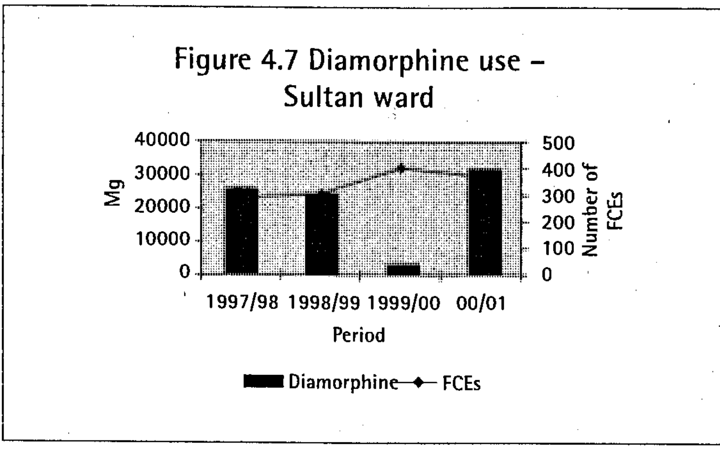
1. Dryad ward away day notes, Gosport War Memorial Hospital, 22 January 2001, 18 May 1998
2. Community hospital service plan 2001/2002, Portsmouth Healthcare NHS Trust, undated
3. Community hospitals GP bed service plan 2000/2001, Portsmouth Healthcare NHS Trust, 30 November 1999
4. Intermediate care and rehabilitation services proposal, Fareham and Gosport primary care groups, May 2000.
5. Team objectives 1999/2000 – Sultan ward, Portsmouth Healthcare NHS Trust, 21 November 2001
6. Gosport War Memorial Hospital key objectives 2000/2001, 1998/1999, 1997/1998 and 1996/1997, Portsmouth Healthcare NHS Trust
7. Gosport War Memorial Hospital leaflet and general information, Portsmouth Healthcare NHS Trust, undated
8. Gosport health improvement programme (HIMP) 2000-2002, Fareham and Gosport primary care groups, undated
9. Fareham and Gosport primary care groups intermediate care and rehabilitation services, Fareham and Gosport primary care groups, undated
10. Patient throughput data from Sultan, Dryad and Daedalus wards 1997/1998 – 2000/2001, Fareham and Gosport primary care groups, April 2002
11. Fareham and Gosport staff management structure, community hospitals, Portsmouth Healthcare NHS Trust, 25 October 2001
13. Fareham and Gosport locality division structure diagram, Portsmouth Healthcare NHS Trust, 25 October 2001
14. Fareham and Gosport older persons' locality implementation group progress report. Isle of Wight, Portsmouth and South East Hants Health Authority, Fareham and Gosport primary care groups, undated
15. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
16. Correspondence from department of medicine for elderly people re: national sentinel audit of stroke 1999, Portsmouth Healthcare NHS Trust, 8 March 2000
17. Job description: Lead consultant department of medicine for elderly people (draft 4), Portsmouth Healthcare NHS Trust, February 1999
18. Job description: clinical assistant position to the geriatric division in Gosport, Portsmouth and South East Hampshire Health Authority, April 1988
19. Job description: service manager (H Grade) department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 29 August 2000
20. Job description: Service manager, community hospitals Fareham and Gosport, Portsmouth Healthcare NHS Trust, February 2000
21. University of Portsmouth, Clinical nursing governance in a department of elderly medicine: an exploration of key issues and proposals for future development, Portsmouth Healthcare NHS Trust and Portsmouth University, May 2000

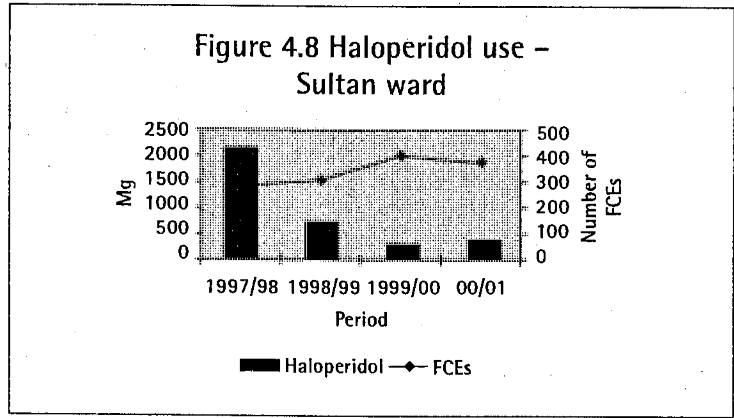


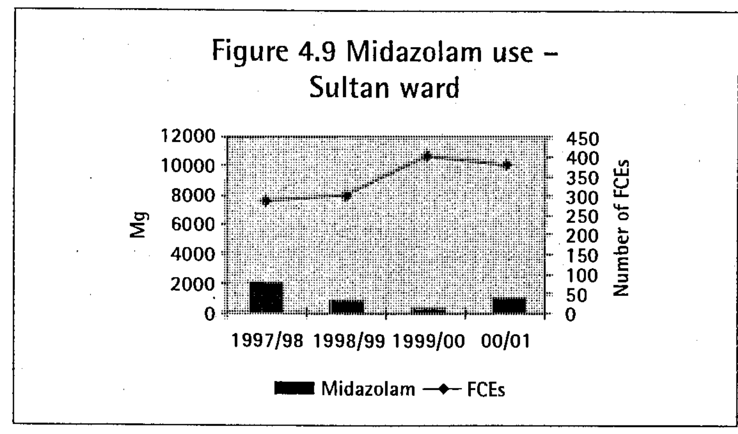




GMC100829-0333







103. Anonymised correspondence on complaints relating to Gosport War Memorial Hospital since 1998

104. Learning from experience: action from complaints and patient based incidents, 1998-2001, Portsmouth Healthcare NHS Trust

105. Handling complaints course facilitators notes, Portsmouth Healthcare NHS Trust, 21 May 1999

106. Community hospitals governance framework, January 2001

107. Community hospitals and Portsmouth Healthcare NHS Trust clinical governance development plan, 2001- 2002

108. General rehabilitation clinical governance group, minutes of meeting 6 September 2001

109. Stroke service clinical governance meeting, minutes of meeting 12 October 2001

110. Continuing care clinical governance group, minutes of meeting 7 November 2001, Portsmouth Healthcare NHS Trust

111. Community hospitals clinical leadership programme update, Portsmouth Healthcare NHS Trust, 19 November 2001

112. Practice development programme: community hospitals clinical governance, Portsmouth Healthcare NHS Trust, March 1999

113. Third quarter quality/clinical governance report, community hospitals service lead group, Portsmouth Healthcare NHS Trust, January 2000

114. Community hospitals clinical governance baseline assessment action plan, September 1999

115. Clinical governance: minimum expectations of NHS trusts and primary care trusts from April 2000. Action plan - review March 2001, Portsmouth Healthcare NHS Trust, undated

116. Clinical governance annual report 2000/2001 and 1999/2000, Portsmouth Healthcare NHS Trust

117. Risk event forms and instructions, Portsmouth Healthcare NHS Trust, undated

118. Clinical governance baseline assessment trust wide report, 1999, Portsmouth Healthcare NHS Trust, undated

119. Trust clinical governance panel meeting minutes on 16 May 2001, Portsmouth Healthcare NHS Trust

120. Memorandum re: implementation of clinical governance, Portsmouth Healthcare NHS Trust, 11 June 1999

121. Risk management strategy 2000/2003, 1999/2002 and 1998/2001, Portsmouth Healthcare NHS Trust

122. Gosport War Memorial Hospital patient survey action plan, Portsmouth Healthcare NHS Trust, (undated)

GMC100829-0334

81. Training on demand: working in partnership, Portsmouth Healthcare NHS Trust, undated
82. Programme of training events 2001-2002, Portsmouth Healthcare NHS Trust, undated
83. Sultan ward leaflet, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust
84. Post mortem information for relatives and hospital post mortem consent form, Portsmouth Healthcare NHS Trust, January 2000
85. Proposal for Portsmouth Healthcare NHS Trust: the provision of an employee assistance programme for Portsmouth Healthcare NHS Trust, Corecare, 16 March 2000
86. Gosport War Memorial Hospital chaplains' leaflet, Portsmouth Healthcare NHS Trust, undated
87. Gosport War Memorial Hospital, chaplains and Portsmouth Healthcare NHS Trust: because we care, community health services – leaflets, Portsmouth Healthcare NHS Trust, undated
88. Talking with dying patients, loss death and bereavement, staff handout, no author, undated
89. Multidisciplinary post registration development programme, 2001
90. Gerontological nursing programme: proposal for an integrated work based learning and practice development project between the RCN's gerontological nursing programme, Portsmouth Health Care NHS Trust, PCTs and Portsmouth University: COMMUNITY HOSPITALS, Royal College of Nursing, version 2.0 2001
91. Multidisciplinary post registration year 2000-2001: lecture programme, Portsmouth Healthcare NHS Trust, November 2001
92. Training programme 2002 and in service training: list of lectures, Portsmouth Healthcare NHS Trust, undated
93. Occupational therapy service – supervision manual, Portsmouth Healthcare NHS Trust, Portsmouth City Council, Hampshire County Council Social Service department, undated
94. Acute life threatening events recognition and treatment (ALERT): A multiprofessional University of Portsmouth course in care of the acutely ill patient, October 2000
95. Training and development for nursing staff in Portsmouth Healthcare NHS Trust community hospitals relating to intermediate care: Progress report, Portsmouth Healthcare NHS Trust, 12 February 2001
96. E-learning at St James's: catalogue of interactive training programmes, November 2001
97. Valuing diversity pamphlet: diversity matters, Portsmouth Healthcare NHS Trust, undated
98. Procedural statement – individual performance review: recommended documentation and guidance notes, personnel director, Portsmouth Healthcare NHS Trust, April 2001
99. IPR audit results 2000, community hospitals service lead group, 22 March 2001
100. Clinical nursing development, promoting the best practice in Portsmouth Healthcare, Portsmouth Healthcare NHS Trust, January 1998
101. An evaluation of clinical supervision activity in nursing throughout Portsmouth Healthcare NHS Trust, Portsmouth Healthcare NHS Trust, December 1999
102. Your views matter: making comments or complaints about our services, Portsmouth Healthcare NHS Trust, undated

Assessment and management of pain

4.6 Part of the individual total assessment of each patient includes an assessment of any pain they may be experiencing and how this is to be managed. In 1998, the trust did not have a policy for the assessment and management of pain. This was introduced in April 2001, in collaboration with Portsmouth Hospitals NHS Trust, and is due for review in 2003. The stated purpose of the document was to identify mechanisms to ensure that all patients have early and effective management of pain or distress. The policy placed responsibility for ensuring that pain management standards are implemented in every clinical setting and sets out the following:

- the prescription must be written by medical staff following diagnosis of type(s) of pain and be appropriate given the current circumstances of the patient
- if the prescription states that medication is to be administered by continuous infusion (syringe driver), the rationale for this decision must be clearly documented
- all prescriptions for drugs administered via a syringe driver must be written on a prescription sheet designed for this purpose

4.7 CHI has also seen evidence of a pain management cycle chart and an 'analgesic ladder'. The analgesic ladder indicates the drug doses for different levels and types of pain, how to calculate opiate doses, gives advice on how to evaluate the effects of analgesia and how to observe for any side effects. Nurses interviewed by CHI demonstrated a good understanding of pain assessment tools and the use of the analgesic ladder.

4.8 CHI was told by some nursing staff that following the introduction of the policy, it took longer for some patients to become pain free and that medical staff were apprehensive about prescribing diamorphine. Nurses also spoke of a reluctance of some patients to take pain relief. CHI's case note review concluded that two of the 15 patients reviewed were not prescribed adequate pain relief for part of their stay in hospital.

4.9 Many staff interviewed referred to the "Wessex guidelines". This is a booklet called *Palliative care handbook guidelines on clinical management* drawn up by Portsmouth Healthcare NHS Trust, the Portsmouth Hospitals NHS Trust and a local hospice, in association with the Wessex palliative care units. These guidelines were in place in 1998. Although the section on pain focuses on patients with cancer, there is a clear highlighted statement in the guidelines that states "all pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold".

4.10 The Wessex guidelines are comprehensive and include detail, in line with British National Formulary recommendations, on the use, dosage, and side effects of medicines commonly used in palliative care. The guidelines are not designed for a rehabilitation environment.

4.11 CHI's random case note review of 15 recent admissions concluded that the pain assistance and management policy is being adhered to. CHI was told by staff of the previous practice of anticipatory prescribing of palliative opiates. As a result of the pain and assessment policy, this practice has now stopped.

GMC100829-0335

Prescription writing policy

4.12 This policy was produced jointly with the Portsmouth Hospitals NHS Trust in March 1998. The policy covered the purpose, scope, responsibilities and requirements for prescription writing, medicines administered at nurses' discretion and controlled drugs. A separate policy covers the administration of intravenous medicines.

4.13 The policy has a section on verbal prescription orders, including telephone orders, in line with UKCC guidelines. CHI understands that arrangements such as these are common practice in GP led wards and work well on the Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours. These arrangements were also confirmed by evidence found in CHI's case note review.

Administration of medicines

4.14 Medicines can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and via a syringe driver. Some of the medicines used in the care of older people can be delivered by a syringe driver, which delivers a continuous subcutaneous infusion of medication. Syringe drivers can be an entirely appropriate method of medicine administration that provides good control of symptoms with little discomfort or inconvenience to the patient. Guidance for staff on prescribing via syringe drivers is contained within the trust's policy for assessment and management of pain. The policy states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

4.15 Evidence from CHI's case note review demonstrated good documented examples of communication with both patients and relatives over medication and the use of syringe drivers and the application of the trust's policy.

4.16 Information provided by the trust indicates that only two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five nurses had also completed a drugs competencies course. No qualified nurses from Dryad or Daedalus ward had taken part in either course between 1998 and 2001. Some nursing and healthcare support staff spoke of receiving syringe driver information and training from a local hospice.

Role of nurses in medicines administration

4.17 Registered nurses are regulated by the Nursing and Midwifery Council, a new statutory body which replaced the United Kingdom Central Council on 1 April 2002. Registered nurses must work within their code of professional conduct (UKCC, June 1992). The scope of professional practice clarified the way in which registered nurses are personally accountable for their own clinical practice and for care they provide to patients. The standards for the administration of medicines (UKCC, October 1992) details what is expected of nurses carrying out this function.

Psychiatric involvement policy, November 2001; Induction training policy, October 1999 Handling patient related complaints policy, Portsmouth Healthcare NHS Trust, January 2000; Domestic abuse in the workplace policy, July 2000

61. Medicines policy incorporating the IV policy, final draft – version 3.5, Portsmouth Hospitals NHS Trust, Royal Hospital Haslar, Portsmouth Healthcare NHS Trust, August 2001
62. Non emergency patient transport request form, Portsmouth Hospitals and Healthcare NHS Trust, undated
63. Patient transport – standards of service, Portsmouth Healthcare NHS Trust, Development Directorate, March 2001
64. Booking criteria and standards of service – criteria for use of non emergency patient transport, Portsmouth Hospitals and Healthcare NHS Trust and Hampshire Ambulance Trust, undated
65. Prescribing formulary, Portsmouth District October 2001, Portsmouth Hospitals NHS Trust, Portsmouth Healthcare NHS Trust, General Medical Practitioners, Portsmouth and South East Hampshire Health Authorities and Royal Hospital Haslar (not complete)
66. Wessex palliative care handbook: guidelines on clinical management, fourth edition, Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, The Rowans (Portsmouth Area Hospice), undated
67. National sentinel clinical audit, evidence based prescribing for older people: Report of national and local results, Portsmouth Healthcare NHS Trust, undated
68. Compendium of drug therapy guidelines 1998 (for adult patients only), Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, 1998
69. Draft protocol for prescription and administration of diamorphine by subcutaneous infusion, medical director, Portsmouth Healthcare NHS Trust, 15 December 1999
70. Medicines and prescribing committee meeting: agendas 3 February 2000, 4 May 2001, 6 April 2000, 6 July 2000, 3 November 2000
71. Medicines and prescribing committee meeting: minutes 3 November 2000, 5 January 2001
72. Correspondence: protocol for prescription administration of diamorphine by subcutaneous infusion, Portsmouth Healthcare NHS Trust, 7 February 2000, 11 February 2000
73. Correspondence: Portsmouth Healthcare NHS Trust syringe driver control, Portsmouth Healthcare NHS Trust, 21 February 2000
74. Correspondence: diamorphine guidelines, Portsmouth Healthcare NHS Trust, 21 February 2000
75. Audit of prescribing charts: questionnaire Portsmouth Healthcare NHS Trust, undated
76. Administration of controlled drugs – the checking role for support workers: guidance note for ward/clinical managers, Portsmouth Healthcare NHS Trust, February 1997
77. Scoresheet – medicines management standard 2001/2002, Portsmouth Healthcare NHS Trust, undated
78. Organisational controls standards, action plan 2000/2001, Portsmouth Healthcare NHS Trust, November 2001
79. Diagram of Medicines Management Structure, Portsmouth Healthcare NHS Trust, 16 October 2000
80. Summary medicines use 1997/1998 to 2000/2001 for wards Dryad, Daedalus and Sultan, Portsmouth Hospitals NHS Trust pharmacy service, April 2002

GMC100829-0336

41. Human resource management, Portsmouth and South East Hampshire Health Authority Community Health Care Services, November 1991

42. Audit of standards of oral hygiene within the stroke service, Portsmouth Healthcare NHS Trust November 1999-April 2000

43. Clinical Stroke service guidelines, Department of medicine for elderly people, undated

44. Reaudit evaluation of compliance with revised handling assessment guidelines, Portsmouth Healthcare NHS Trust, June 1998-November 1998

45. Feeding people, trust wide reaudit of nutritional standards, Portsmouth Healthcare NHS Trust, November 2001

46. Trust records strategy, records project manager, Portsmouth Healthcare NHS Trust March 2001

47. A guide to medical records, a pocket guide to all medical staff, Portsmouth Healthcare NHS Trust, June 2000

48. Health records all specialities core standards and procedures, Portsmouth Healthcare NHS Trust (incorporating East Hants Primary Care Trust and Portsmouth City Primary Care Trust), December 1998 updated February 2000 and May 2001

49. Referral to old age psychiatry form, Portsmouth Healthcare NHS Trust, undated

50. Patients affairs procedure - death certification and post mortems, department of medicine for elderly people, Queen Alexandra Hospital, (undated)

51. Audit of compliance with bed rails guidelines in community hospitals, Portsmouth Healthcare NHS Trust, August 2001

52. Patient flows, organisational chart, 24 October 2001

53. Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts Joint Generic Transfer Document: Protocol for the transfer to GP step down beds, Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts, November 2000

54. Discharge summary form, guidance notes for completion, Portsmouth Healthcare NHS Trust, 21 November 2001

55. Audit of patient records, December 1997-July 1998, Portsmouth Healthcare NHS Trust

56. Audit of nutritional standards, October 1997-April 1998, Portsmouth Healthcare NHS Trust, undated

57. Falls policy development - strategy to reduce the number of falls in community hospitals, Portsmouth Healthcare NHS Trust, undated

58. Minutes of falls meetings held on 26 July 2001,13 June 2001, 26 February 2001, 18 January 2001, 23 November 2000, 5 October 2000, Portsmouth Healthcare NHS Trust

59. Stepping stones: how the need for stepping stones came about, Portsmouth Healthcare NHS Trust, undated

60. Portsmouth Healthcare NHS Trust Policies: Resuscitation status policy, April 2000; Whistleblowing policy, February 2001; Risk management policy, January 2001; Recording and reviewing risk events policy, May 2001; Control and administration of medicines by nursing staff policy, January 1997; Prescription writing policy, July 2000; Policy for assessment and management of pain, May 2001; Training and education policy, April 2001; Bleep holder policy review, 15 May 2001; Prevention and management of pressure ulcers policy, May 2001; Prevention and management of malnutrition within trust residential and hospital services, November 2000; Client records and record keeping policy, December 2000; Trust corporate policies, guidance for staff, revised August 2000;

4.18 Underpinning all of the regulations that govern nursing practice, is the requirement that nurses act in the best interest of their patients at all times. This could include challenging the prescribing of other clinical staff.

Review of medicines

4.19 The regular ward rounds and multidisciplinary meetings should include a review of medication by senior staff, which is recorded in the patient's case notes. CHI recognises the complexity of multidisciplinary meetings. Despite this, a process should be found to ensure that effective and regular reviews of patient medication take place by senior clinicians and pharmacy staff.

Structure of pharmacy

4.20 Portsmouth Healthcare NHS Trust has a service level agreement for pharmacy services with the local acute trust, Portsmouth Hospitals NHS Trust. An E grade pharmacist manages the contract locally and the service provided by a second pharmacist, who is the lead for older peoples' services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing workload. Pharmacy staff were confident that ward pharmacists would now challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to put the trust's *A compendium of drug therapy guidelines* on the intranet, although this is not easily available to all staff.

4.21 Pharmacy training for non pharmacy staff was described as "totally inadequate" and not taken seriously. Nobody knew of any training offered to clinical assistants.

4.22 There were no systems in place in 1998 for the routine review of pharmacy data which could have alerted the trust to any unusual or excessive patterns of prescribing, although the prescribing data was available for analysis.

KEY FINDINGS

1. 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 (the "Wessex guidelines") but this was inappropriately applied to patients admitted for rehabilitation.

2. 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.

3. The usage of diamorphine, midazolam and haloperidol has declined in recent years, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998.

GMC100829-0337

4. CHI found some evidence to suggest a recent reluctance amongst clinicians to prescribe sufficient pain relieving medication. Despite this, diamorphine usage on Sultan ward 2000/2001 showed a marked increase.

5. CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Anticipatory prescribing is no longer evident on these wards. 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.

6. CHI found little evidence to suggest that thorough individual total patient assessments were being made by multidisciplinary teams in 1998. CHI's case note review concluded that this approach to care had been developed in recent years.

7. Pharmacy support to the wards in 1998 was inadequate. The trust was able to produce pharmacy data in 2002 relating to 1998. A system should have been in place to review and monitor prescribing at ward level, using data such as this as a basis.

RECOMMENDATIONS

1. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

2. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

3. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

4. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

20. Correspondence: re Healthcall regarding contract for 2002, Healthcall business manager, March 2002

21. Patient environment assessment and action plan, Portsmouth Healthcare NHS Trust, August and September 2000

22. Combined five year capital programme 2001/2002-2005/2006, Portsmouth Healthcare NHS Trust, Portsmouth City Primary Care Trust, East Hampshire NHS Primary Care Trust, 8 November 2001

23. Portsmouth Healthcare NHS Trust: Investors in People report, Western Training and Enterprise Council, July 1999

24. Portsmouth Healthcare NHS Trust, Quality report – governance indicators, quarter ending 30 June 2001, 31 March 2001, 31 December 2000, 30 September 2000, 30 June 2000, 31 March 2000, 31 December 1999, 30 September 1999, 30 June 1999, 31 March 1999, 31 December 1998, 30 September 1998, 30 June 1998, 31 March 1998, 31 December 1997, 30 September 1997, 30 June 1997

25. Annual quality report to Portsmouth and South East Hampshire Health Authority (quarter 3 2000/2001), Portsmouth Healthcare NHS Trust, 27 February 2001

26. Improving quality – steps towards a First class service, Portsmouth Healthcare NHS Trust September 1998

27. Infection control services, Portsmouth Hospitals NHS Trust and Portsmouth Healthcare NHS Trust, Nursing practice audit, Portsmouth Healthcare NHS Trust, 9 May 2001

28. Emergency incidents originating at Gosport War Memorial Hospital, Hampshire Ambulance Service NHS Trust, April 2000-February 2002

29. Staff handbook, Portsmouth Healthcare NHS Trust, undated

30. Junior doctors' accreditation information, pack supplied by Portsmouth Healthcare NHS Trust, undated

31. GP contracts for trust working, Portsmouth Healthcare NHS Trust, December 1979-May 2001

32. GP contracts for trust working, Out of hours GP contract, Portsmouth Healthcare NHS Trust, April 1999-March 2000, June 2001-March 2002

33. Strategy for employing locum medical staff, Portsmouth Healthcare NHS Trust, undated

34. The development of clinical supervision for nurses, nurse consultant, adult mental health services, Portsmouth Healthcare NHS Trust undated

35. Correspondence/memorandum re: staff opinion survey results, Portsmouth Healthcare NHS Trust, 18 December 2001

36. Staff opinion survey 2000, Portsmouth Healthcare NHS Trust undated

37. Common actions arising from staff opinion survey results, personnel department, 19 October 2001

38. Memorandum re: senior managers on call, Portsmouth Healthcare NHS Trust, 29 September 2000

39. Personnel and human resources/management strategy and action plan, Portsmouth Healthcare NHS Trust, personnel director, October 2001

40. Strategy for human resource management and important human resource issues, Portsmouth Healthcare NHS Trust, personnel director, October 1996

GMC100829-0338

Healthcare NHS Trust to local Primary Care Trusts and West Hampshire NHS Trust, South East regional office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Hampshire Health Authority, September 2001

4. Dissolution project proposal, Portsmouth Healthcare Trust, undated

5. Trust dissolution: summary of meeting to agree the future management arrangements for risk and clinical governance systems and groups, Portsmouth Healthcare NHS Trust, 1 November 2001

6. Looking forward... the next five years 1995-2000, Portsmouth Healthcare NHS Trust, September 1994

7. Business plans 2000-2001, 1999-2000, 1998-1999, 1997-1998, Portsmouth Healthcare NHS Trust

8. Health improvement programme 2000-2003, Portsmouth and south east Hampshire, Isle of Wight, Portsmouth and South East Hampshire, April 2000

9. Fareham health improvement programme 2000-2002, Fareham and Gosport Primary Care Groups, undated

10. A report on a future Patient Advice Liaison Service for Fareham & Gosport Primary Care Trust, Portsmouth Healthcare NHS Trust, November 2001

11. Gosport War Memorial Patient Survey results, Portsmouth Healthcare NHS Trust, November 2001, October 2001, July 2001.

12. 2001/2002 Services and Financial Framework (SAFF) cost and service pressures, Portsmouth Healthcare NHS Trust, undated

13. Gosport War Memorial Hospital outpatient clinics rota, 9 July 2001

14. User involvement in service development: A framework, Portsmouth Healthcare NHS Trust, undated

15. Isle of Wight, Portsmouth & South East Hampshire Health Authority joint investment plan for older people 2001-2002, Isle of Wight, Portsmouth & South East Hampshire Health Authority, undated

16. Portsmouth Healthcare NHS Trust, trust board agendas and strategic briefing documents:

    Trust board strategic briefing 18 October 2001, 19 July 2001, 21 June 2001, 18 January 2001, 19 October 2000, 20 July 2000, 15 June 2000, 20 April 2000, 20 January 2000, 21 October 1999, 15 July 1999, 17 June 1999, 15 April 1999, 21 January 1999, 22 October 1998, 24 September 1998

    Public meeting of the trust board 20 September 2001, 17 May 2001, 15 February 2001, 16 November 2000, 21 September 2000, 18 May 2000, 17 February 2000, 18 November 1999, 16 September 1999, 20 May 1999, 18 February 1999, 19 November 1998

    Agenda for part two of meeting of trust board 20 September 2001, 17 May 2001, 15 February 2001, 16 November 2000, 21 September 2000, 18 May 2000, 17 February 2000, 18 November 1999, 16 September 1999, 20 May 1999, 18 February 1999, 19 November 1998, 24 September 1998

17. Divisional review 2000 Gosport and Fareham division, Portsmouth Healthcare NHS Trust, 8 February 2000, 10 August 2000, 16 May 2000, 11 November 1999

18. National service framework: older people steering group (district wide implementation team) documents, Isle of Wight, Portsmouth and South East Hampshire health authority, undated

19. Correspondence: re Healthcall data 2001 analysis, Knapman practice, 22 June 2002

5 | Quality of care and the patient experience

Introduction

5.1 This chapter details CHI's findings following contact with patients and relatives. This needs to be put into the context of the 1,725 finished consultant episodes for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Details of the methods used to gain an insight into the patient experience and of the issues raised with CHI are contained in appendix B.

Patient expeience

5.2 As with all patients being cared for when they are sick and vulnerable, it is important to treat each person as a whole. For this reason, the total holistic assessment of patients is critical to high quality individual care tailored to each patient's specific needs. The following sections are key elements (though not an exhaustive list) of total assessments which were reported to CHI by stakeholders.

5.3 CHI examined in detail the experience of older patients admitted to the Gosport War Memorial Hospital between 1998 and 2001 and that of their relatives and carers. This was carried out in two ways. Firstly, stakeholders were invited, through local publicity, to make contact with CHI. The police also wrote to relatives who had expressed concern to them informing them of CHI's investigation. Views were invited in person, in writing, over the telephone and by questionnaire. A total of 36 patients and relatives contacted CHI during the investigation.

5.4 Secondly, CHI made a number of observation visits, including at night, to Daedalus, Dryad and Sultan wards during the site visit week in January 2002. Some of the visits were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed.

Stakeholder views

5.5 The term stakeholder is used by CHI to define a range of people that are affected by, or have an interest in, the services offered by an organisation. CHI heard of a range of both positive and less positive experiences, of the care of older people. The most frequently raised concerns with CHI were: the use of medicines, the attitude of staff, continence management, the use of patients' own clothing, transfer arrangements between hospitals and nutrition and fluids. More detail on each of these areas is given below.

GMC100829-0339

5.6 Relatives expressed concern around a perceived lack of nutrition and fluids as patients neared the end of their lives: "no water and fluids for last four days of life". Comments were also raised about unsuitable, unappetising food and patients being left to eat without assistance. A number of stakeholders commented on untouched food being cleared away without patients being given assistance to eat.

5.7 Following comments by stakeholders, CHI reviewed the trust policy for nutrition and fluids. The trust conducted a trust wide audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy *Feeding People*. The trust policy, *Prevention and management of malnutrition* (2000), included the designation of an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure full compliance. The standards state:

- all patients must have a nutritional risk assessment on admission
- registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary
- all staff must ensure that documented evidence supports the continuity of patient care and clinical practice
- all clinical areas should have a nominated nutritional representative who attends training/updates and is a resource for colleagues
- systems should be in place to ensure that staff have the required training to implement and monitor the *Feeding People* standards

5.8 A second trust audit in 2000 concluded that, overall, the implementation of the *Feeding People* standards had been "very encouraging". However, there were concerns about the lack of documentation and a sense of complacency as locally written protocols had not been produced throughout the service.

5.9 CHI's review of recent case notes concluded that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses appeared unable to make swallowing assessments out of hours; this could lead to delays in receiving nutrition over weekends, for example, when speech and language therapy staff were not available.

5.10 Continence management is an important aspect of the care of older people, the underlying objective is to promote or sustain continence as part of the holistic management of care, this includes maintaining skin integrity (prevention of pressure sores). Where this is not possible, a range of options including catheterisation are available and it is imperative that these are discussed with patients, relatives and carers. Some stakeholders raised concerns regarding the 'automatic' catheterisation of patients on admission to the War Memorial. "They seem to catheterise everyone. My husband was not incontinent; the nurse said it was done mostly to save time". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.

5.11 CHI's review of recent case notes found no evidence of inappropriate catheterisation of patients in recent months.

APPENDIX A

Documents reviewed by CHI and/or referred to in the report

A) NATIONAL DOCUMENTS

1. Modern Standards and Service Models, Older People, National Service Framework for Older People, Department of Health, March 2001
2. 'Measuring disability a critical analysis of the Barthel Index', British Journal of Therapy and Rehabilitation, April 2000, Vol 7, No 4
3. The Public Interest Disclosure Act 1998 – whistleblowing in the NHS, NHS Executive, August 1999
4. Guidelines for the administration of medicines, (including press statement) United Kingdom Central Council for Nursing, Midwifery and Health Visiting, October 2000
5. Extension of independent nursing prescribing, items prescribable by nurses under the extended scheme, Department of Health, February 2002
6. Essence of Care: patient-focused benchmarking for healthcare practitioners, Department of Health, February 2001
7. Caring for older people: A nursing priority, integrated knowledge, practice and values, The nursing and midwifery advisory committee, March 2001
8. British National Formulary 41, British Medical Association, Royal Pharmaceutical Society of Great Britiain, 2001
9. Consent – What you have a right to expect: a guide for relatives and carers, Department of Health, July 2001
10. Making a Difference, strengthening the nursing, midwifery and health visiting contribution to health and healthcare, Summary, The Department for Health, July 1999
11. Improving Working Lives Standard, NHS employers commited to improving the working lives of people who work in the NHS, Department of Health, September 2000
12. The NHS plan, a plan for investment, a plan for reform, Chapter 15, dignity, security and independence in old age, The Department of Health, July 2000
13. Standards for health and social care services for older people, The Health Advisory Service 2000, May 2000
14. Reforming the NHS Complaints Procedure: a listening document, The Department of Health, September 2001

B) DOCUMENTS RELATING TO PORTSMOUTH HEALTHCARE NHS TRUST

1. Our work, our values – a guide to Portsmouth Healthcare NHS Trust, Portsmouth Healthcare NHS Trust, undated
2. Annual reports, Portsmouth Healthcare NHS Trust, 2000-2001, 2000, 1998-1999
3. Local health, local decisions – proposals for the transfer of management responsibility for local health services in Portsmouth and south east Hampshire from Portsmouth

GMC100829-0340

8.15 More recently, the Fareham and Gosport PCT has undertaken a basic audit based on the prescription sheets and medical records of patients cared for on Sultan, Dryad and Daedalus wards during two weeks in June 2002. The trust concluded "that the current prescribing of opiates, major tranquilisers and hyocine was within British National Formulary guidelines." No patients were prescribed midazolam during the audit timeframe.

KEY FINDINGS

1. The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

2. Although a system was in place to record risk events, understanding of clinical risk was not universal. The trust had a whistle blowing policy, but not all staff were aware of it. The policy did not make it sufficiently clear that staff could raise concerns outside of the usual management channels if they wished.

RECOMMENDATIONS

1. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

2. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

3. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

4. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

5.12 The use of pain relieving medicines and the use of syringe drivers to administer them was commented on by a number of relatives. One relative commented that her mother "certainly was not in pain prior to transfer to the War Memorial". Although a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI also received comments that families would have liked more information: "Doctors should disclose all drugs, why [they are being used] and what the side effects are. There should be more honesty".

5.13 Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by their families. "They were never in their own clothes". Relatives also thought patients being dressed in other patients' clothes was a potential cross infection risk. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes. This is an important means by which patients' dignity can be maintained.

5.14 Concern was expressed regarding the physical transfer of patients from one hospital to another. Amongst concerns were lengthy waits prior to transfer, inadequate clothing and covering during the journey and the methods used to transfer patients. One person described their relative as being "carried on nothing more than a sheet". CHI learnt that this instance was acknowledged by Portsmouth Healthcare NHS Trust, who sought an apology from the referring hospital, which did not have the appropriate equipment available.

5.15 Though there were obvious concerns regarding the transfer of patients, during the period of the investigation, the Hampshire Ambulance Service NHS Trust, who were responsible for patient transfers between hospitals, received no complaints relating to the transfer of patients to and from the Gosport War Memorial Hospital.

5.16 Comments about the attitude of staff ranged from the very positive "Everyone was so kind and caring towards him in both Daedalus and Dryad wards" and "I received such kindness and help from all the staff at all times" to the less positive "I was made to feel an inconvenience because we asked questions" and "I got the feeling she had dementia and her feelings didn't count".

Outcome of CHI observation work

5.17 CHI spent time on Dryad, Sultan and Daedalus wards throughout the week of 7 January 2002 to observe the environment in which care was given, the interactions between staff and patients and between staff. Ward staff were welcoming, friendly and open. Although CHI observed a range of good patient experiences this only provides a 'snap shot' during the site visit and may not be fully representative. However, many of the positive aspects of patient care observed were confirmed by CHI's review of recent patient notes.

GMC100829-0341

Ward environment

5.18 All wards were built during the 1991 expansion of the hospital and are modern, welcoming and bright. This view was echoed by stakeholders, who were complimentary about the décor and patient surroundings. Wards were tidy, clean and fresh smelling.

5.19 Day rooms are pleasant and Daedalus ward has direct access to a well designed garden suitable for wheelchair users. The garden is paved with a variety of different textures to enable patients to practice mobility. There is limited storage space in Daedalus and Dryad wards and, as a result, the corridors had become cluttered with equipment. This can be problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe.

5.20 CHI saw staff address patients by name in a respectful and encouraging way and saw examples of staff helping patients with dressing and holding friendly conversations. The staff handovers observed were well conducted, held away from the main wards areas and relevant information about patient care was exchanged appropriately.

5.21 Mealtimes were well organised with patients given a choice of menu options and portion size. Patients who needed help to eat and drink were given assistance. There appeared to be sufficient staff to serve meals, and to note when meals were not eaten. CHI did not observe any meals returned untouched. Healthcare support workers told CHI that they were responsible for making a note when meals were not eaten.

5.22 There are day rooms where patients are able to watch the television and large print books, puzzles and current newspapers are provided. CHI saw little evidence of social activities taking place, although some patients did eat together in the day room. Bells to call assistance are situated by patients' beds, but are less accessible to patients in the day rooms. The wards have an activities coordinator, although the impact of this post has been limited.

5.23 Daedalus ward has a communication book by each bed for patients and relatives to make comments about day to day care. This is a two way communication process which, for example, allows therapy staff to ask relatives for feedback on progress and enables relatives to ask for an appointment with the consultant.

5.24 CHI observed two medicine rounds, both of which were conducted in an appropriate way with two members of staff jointly identifying the patient and checking the prescription sheet. One member of staff handed out the medicines while the other oversaw the patients as medicines are taken. Medicines are safely stored on the wards in locked cupboards.

8.10 The trust introduced an operational policy for recording and reviewing risk events in 1994. New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non clinical risk. The same trust policy was used to report clinical and non clinical risks and accidents. All events were recorded in the trust's risk event database (CAREKEY). This reporting system was also used for near misses and medication errors. Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, although CHI was less confident that medical staff regularly identified and reported risks. CHI was told that risk forms were regularly submitted by wards in the event of staff shortages. Staff shortage was not one of the trust's risk event definitions.

8.11 The clinical governance development plan for 2001/2002 stated that the focus for risk management in 2000/2001 was the safe transfer of services to successor organisations, with the active involvement of PCTs and PCGs in the trust's risk management group. Meetings were held with each successor organisation to agree future arrangements for areas such as risk event reporting, health and safety, infection control and medicines management.

Raising concerns

8.12 The trust had a whistle blowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. The policy sets out the process staff should follow if they wished to raise a concern about the care or safety of a patient "that cannot be resolved by the appropriate procedure". NHS guidance requires systems to enable concerns to be raised outside the usual management chain. Most staff interviewed were clear about how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. Fewer staff were aware of the trust's whistle blowing policy.

Clinical audit

8.13 CHI was given no positive examples of changes in patient care or prescribing as a result of clinical audit outcomes. Despite a great deal of work on revising and creating policies to support good prescribing and pain management, there was no planned audit of outcome.

8.14 CHI was made aware of two trust audits of medicines since 1998. In 1999, a review of the use of neuroleptic medicines, which includes tranquillisers such as haloperidol, within all trust elderly care continuing care wards concluded that neuroleptic medicines were not being over prescribed. The same review revealed "the weekly medical review of medication was not necessarily recorded in the medical notes". The findings of this audit and the accompanying action plan, which included guidance on completing the prescription chart correctly, was circulated to all staff on Daedalus and Dryad wards. A copy was not sent to Sultan ward. There was a reaudit in late 2001 which concluded that overall use of neuroleptic medicines in continuing care wards remained appropriate.

GMC100829-0342

8.5 The service specific clinical governance committees were led by a designated clinician and included wide clinical and professional representation. Baseline assessments were carried out in each specialty and responsive action plans produced. The medical director and clinical governance manager attended divisional review meetings and reported key issues back to the clinical governance panel.

8.6 District Audit carried out an audit of the trust's clinical governance arrangements in 1998/1999. The report, dated December 1999, states that the trust had fully complied with requirements to establish a framework for clinical governance. The report also referred to the trust's document, *Improving quality – steps towards a first class service*, which was described as "of a high standard and reflected a sound understanding of clinical governance and quality assurance".

8.7 Whilst commenting favourably on the framework, the District Audit review also noted the following:

- the process for gathering user views should be more focused and the process strengthened
- the trust needed to ensure that in some areas, strategy, policy and procedure is fed back to staff and results in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and reaudited; lessons learnt from complaints and incidents not always used to change practice and that research and development did not always lead to change in practice
- more work needed to be done with clinical staff on openness and the support of staff alerting senior management of poor performance

8.8 Following the review, the trust drew up a trust wide action plan (December 1999) which focused on widening the involvement and feedback from nursing, clinical and support staff regarding trust protocols and procedures, and on making greater use of research and development, clinical audit, complaints, incidents and user views to lead to changes in practice. CHI was told of a link nurse programme to take elements of this work forward.

Risk management

8.9 A trust risk management group was established in 1995 to develop and oversee the implementation of the trust's risk management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The group had links with other trust groups such as the clinical and service audit group, the board and the nursing clinical governance committee. Originally the finance director had joint responsibility for strategic risk with the quality manager; this was changed in the 2000/2003 strategy when the medical director became the designated lead for clinical risk. The trust achieved the clinical negligence scheme for trusts (CNST) level one in 1999. A decision was taken not to pursue the level two standard assessment due to dissolution of the trust in 2002.

Communication with patients, relatives and carers

The trust had an undated user involvement service development framework, which sets out the principles behind effective user involvement within the national policy framework described in the NHS Plan. It is unclear from the framework who was responsible for taking the work forward and within what time frame. Given the dissolution of the trust, a decision was taken not to establish a trust wide Patient Advice and Liaison Service (PALS), a requirement of the NHS Plan. However, work was started by the trust to look at a possible future PALS structure for the Fareham and Gosport PCT.

The Health Advisory Service *Standards for health and social care services for older people* (2000) states that "each service should have a written information leaflet or guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers". CHI saw a number of separate information leaflets provided for patients and relatives during the site visit.

The trust used patient surveys, given to patients on discharge, as part of its patient involvement framework, although the response rate was unknown. Issues raised by patients in completed surveys were addressed by action plans discussed at clinical managers meetings. Ward specific action plans were distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, thermometers were purchased to address the problem. CHI could find no evidence to suggest that the findings from patient surveys were shared across the trust.

Support towards the end of life

Staff referred to the Wessex palliative care guidelines, which are used on the wards and address breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure on Queen Alexandra and St Mary's hospitals to "discharge patients too quickly to Gosport War Memorial Hospital". Staff were aware of increased numbers of medically unstable patients being transferred in recent years.

Both patients and relatives have access to a hospital chaplain, who has links to representatives of other faiths. The trust had a leaflet for relatives *Because we care* which talks about registering the death, bereavement and grieving. The hospital has a designated manager to assist relatives through the practical necessities following a death.

GMC100829-0343

KEY FINDINGS

1. 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.

2. Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

3. The ward environments and patient surroundings are good.

4. Some notable steps had been taken on Daedalus ward to facilitate communication between patients and their relatives with ward staff.

5. CHI was concerned, following the case note review, of the inability of any ward staff to undertake swallowing assessments as required. This is an area of potential risk for patients whose swallowing reflex may have been affected, for example, by a stroke.

6. Opportunities for patients to engage in daytime activities in order to encourage orientation and promote confidence are limited.

7. The trust had a strong theoretical commitment to patient and user involvement.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

2. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

3. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

4. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

5. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

8 | Clinical governance

Introduction

8.1 Clinical governance is about making sure that health services have systems in place to provide patients with high standards of care. The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

8.2 CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems supported the delivery of continuing and rehabilitative inpatient care for older people at the Gosport War Memorial Hospital. This chapter sets out the framework and structure adopted by the trust between 1998 and 2002 to deliver the clinical governance agenda and details those areas most relevant to the terms of reference for this investigation: risk management and the systems in place to enable staff to raise concerns.

Clinical governance structures

8.3 The trust reacted swiftly to the principles of clinical governance outlined by the Department of Health in *A First Class Service* by devising an appropriate management framework. In September 1998, a paper outlining how the trust planned to develop a system for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff interviewed by CHI were aware of the principles of clinical governance and were able to demonstrate how it related to them in their individual roles. Understanding of some specific aspects, particularly risk management and audit, was patchy.

8.4 The medical director took lead responsibility for clinical governance and chaired the clinical governance panel, a sub committee of the trust board. A clinical governance reference group, whose membership included representatives from each clinical service, professional group, non executive directors and the chair of the community health council, supported the clinical governance panel. Each clinical service also had its own clinical governance committee. This structure had been designed to enable each service to take clinical governance forward into whichever PCT it found itself in after April 2002. Since February 2000, the trust used the divisional review process to monitor clinical governance developments.

GMC100829-0344

7.14 Portsmouth Healthcare NHS Trust offered specific training in complaints handling, customer care and loss, death and bereavement, which many staff interviewed by CHI were aware of and had attended.

KEY FINDINGS

1. The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake an 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.

2. 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.

3. Though Portsmouth Healthcare NHS Trust did begin to develop a protocol for the prescription and administration of diamorphine by syringe driver in 1999, the delay in finalising this protocol in April 2001, as part of the policy for the assessment and management of pain, was unacceptable.

4. There has been some, but not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

RECOMMENDATIONS

1. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

2. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

3. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

6 | Staffing arrangements and responsibility for patient care

Responsibility for patient care

6.1 Patient care on Daedalus and Dryad wards at Gosport War Memorial Hospital for the period of the CHI investigation was provided by consultant led teams. A multidisciplinary, multiprofessional team of appropriately trained staff best meets the complex needs of these vulnerable patients. This ensures that the total needs of the patient are considered and are reflected in a care plan, which is discussed with the patient and their relatives and is understood by every member of the team.

Medical responsibility

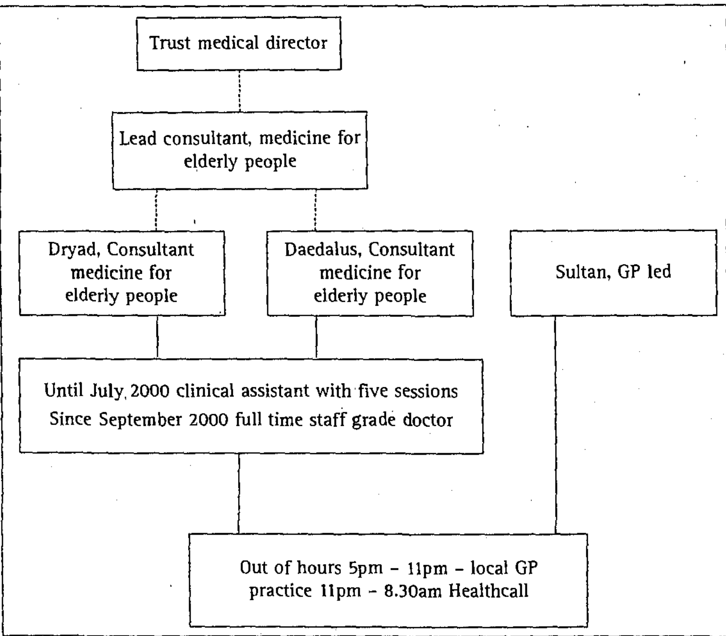
6.2 For the period covered by the CHI investigation, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. This is still the case today. All patients on both wards are admitted under the care of a consultant. Since 1995, there has been a lead consultant for the department of medicine for elderly people who held a two session contract (one session equates to half a day per week) for undertaking lead consultant responsibilities. These responsibilities included overall management of the department and the development of departmental objectives. The lead consultant is not responsible for the clinical practice of individual doctors. The post holder does not undertake any clinical sessions on the War Memorial site. The job description for the post, outlines 12 functions and states that the post is a major challenge for "a very part time role".

6.3 Since 2000, two department of elderly medicine consultants provide a total of 10 sessions of consultant cover on Dryad and Daedalus wards per week. Since September 2000, day to day medical support has been provided by a staff grade physician who was supervised by both consultants. Until July 2000, a clinical assistant provided additional medical support. Both consultants currently undertake a weekly ward round with the staff grade doctor. In 1998, there was a fortnightly ward round on Daedalus ward. On Dryad, ward rounds were scheduled fortnightly, though occurred less frequently.

6.4 CHI feels that the staff grade post is a pivotal, potentially isolated post, due to the distance of Gosport War Memorial Hospital from the main department of medicine for elderly people based at Queen Alexandra Hospital, no full time support from medical colleagues on the wards and a difficulty in attending departmental meetings. In 2001, the trust identified the risk of professional isolation and lack of support at Gosport War Memorial Hospital as a reason not to appoint a locum consultant.

GMC100829-0345

Figure 6.1 Line management accountabilities



(* ·············· this line indicates managerial accountability and not clinical accountability)

General practice role and accountability

6.5 Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation: as clinical assistants employed by the trust, as the clinicians admitting and caring for patients on the GP ward (Sultan) and as providers of out of hours medical support to all patients on each of the three wards.

Clinical assistant role

6.6 Clinical assistants are usually GPs employed and paid by trusts, largely on a part time basis, to provide medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years. Portsmouth Healthcare NHS Trust employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants work as part of a consultant led team and have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

7.10 A draft protocol for the prescription and administration of diamorphine by subcutaneous infusion was piloted on Dryad ward in 1999 and discussed at the trust's Medicines and Prescribing Committee in February and April 2000 following consultation with palliative care consultants. This guidance was eventually incorporated into the joint Portsmouth Healthcare NHS Trust and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain which was introduced in April 2001.

Other trust lessons

7.11 Lessons around issues other than prescribing have been learnt by the trust, though the workshop to draw together this learning was not held until early 2001 when the themes discussed were communication with relatives, staff attitudes and fluids and nutrition. Action taken by the trust since the series of complaints in 1998 are as follows:

- an increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999
- the appointment of a full time staff grade doctor in September 2000 which increased medical cover following the resignation of the clinical assistant
- piloting pain management charts and prescribing guidance approved in April 2001. Nursing documentation is currently under review, with nurse input
- one additional consultant session began in 2000, following a district wide initiative with local PCGs around intermediate care
- nursing documentation now clearly identifies prime family contacts and next of kin information to ensure appropriate communication with relatives
- all conversations with families are now documented in the medical record. CHI's review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff

7.12 Comments recorded in this workshop were echoed by staff interviewed by CHI, such as the difficultly in building a rapport with relatives when patients die a few days after transfer, the rising expectations of relatives and the lack of control Gosport War Memorial staff have over information provided to patients and relatives prior to transfer regarding longer term prognosis.

Monitoring and trend identification

7.13 A key action identified in the 2000/2001 clinical governance action plan was a strengthening of trust systems to ensure that actions following complaints were implemented. Until the dissolution of Portsmouth Healthcare NHS Trust, actions were monitored through the divisional review process, the clinical governance panel and trust board. A trust database was introduced in 1999 to record and track complaint trends. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

GMC100829-0346

7.5 Both the trust and the local community health council (CHC) described a good working relationship. The CHC regretted, however, that their resources since November 2000 had prevented them from offering the level of advice and active support to trust complainants they would have wished. The CHC did continue to support complainants who had contacted them before November 2000. New contacts were provided with a "self help" pack.

7.6 CHI found that letters to complainants in response to their complaints did not always include an explanation of the independent review stage, although this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. The 2000 update of the complaints policy stated that audit standards for complaints handling were good with at least 80% of complainants satisfied with complaint handling and 100% of complaints resolved within national performance targets. The chief executive responded to all written complaints. Staff interviewed by CHI valued the chief executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services.

7.7 Once the police became involved in the initial complaint in 1998, the trust ceased its internal investigation processes. CHI found no evidence in agendas and minutes that the trust board were formally made aware of police involvement. Senior trust managers told CHI that the trust would have commissioned a full internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not preclude full internal clinical investigation. CHI was told that neither the doctor nor portering staff involved in the care and transfer of the patient whose care was the subject of the initial police investigation were asked for statements during the initial complaint investigation.

Trust learning regarding prescribing

7.8 Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter 4). In addition, CHI learnt that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem". This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20mg to 40mg per day.

7.9 Portsmouth Healthcare NHS Trust correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mg a day. CHI understands this protocol to be the Wessex guidelines. Further correspondence in October 1999, indicated that a doctor working on the wards requested a trust policy on the prescribing of opiates in community hospitals.

6.7 From 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states that the clinical assistant was accountable to "named consultant physicians in geriatric medicine". The post holder was responsible for arranging cover for annual leave and any sickness absence with practice partners. The trust and the practice partners did not have a contract for this work. The job description does state that the post is subject to the terms and conditions of hospital medical and dental staff. Therefore, any concerns over the performance of any relevant staff could be pursued through the trust's disciplinary processes. CHI could find no evidence to suggest that this option was considered at the time of the initial police investigation in 1998.

Appraisal and supervision of clinical assistants

6.8 CHI is not aware of any trust systems in place to monitor or appraise the performance of clinical assistants in 1998. This lack of monitoring is still common practice within the NHS. The consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, had no system for supervising the practice of the clinical assistant, including any review of prescribing. CHI found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions.

6.9 CHI is aware of work by the Department of Health on GP appraisal which will cover GPs working as clinical assistants and further work to develop guidance on disciplinary procedures.

Sultan ward

6.10 Medical responsibility for patients on Sultan ward lay with the admitting GP throughout the period of the CHI investigation. The trust issued admitting GPs with a contract for working on trust premises, which clearly states "you will take full clinical responsibility for the patients under your care". CHI was told that GPs visit their patients regularly as well as when requested by nursing staff. This is a common arrangement in community hospitals throughout the NHS. GPs had no medical accountablity framework within the trust.

6.11 GPs managing their own patients on Sultan ward could be subject to the health authority's voluntary process for dealing with doctors whose performance is giving cause for concern. However, this procedure can only be used in regard to their work as a GP, and not any contracted work performed in the trust as a clinical assistant. Again, this arrangement is common throughout the NHS.

GMC100829-0347

Out of hours cover provided by GPs

6.12 Between the hours of 8.30am and 5.00pm on weekdays, hospital doctors employed by the trust manage the care of all patients on Dryad and Daedalus wards. Out of hours medical cover, including weekends and bank holidays, is provided by a local GP practice from 5.00pm to 11.00pm, after which, between 11.00pm and 8.30am, nursing staff call on either the patient's practice or Healthcall, a local deputising service for medical input. If an urgent situation occurs out of hours, staff call 999 for assistance.

6.13 Some staff interviewed by CHI expressed concern about long waits for the deputising service, CHI heard that waiting times for Healthcall to attend a patient could sometimes take between three and five hours. However, evidence provided by Healthcall contradicts this. Nurses expressed concern over Healthcall GPs' reluctance to 'interfere' with the prescribing of admitting GPs on Sultan and Dryad wards. The contract with Healthcall is managed by a local practice.

Appraisal of hospital medical staff

6.14 Since April 2000, all NHS employers have been contractually required to carry out annual appraisals, covering both clinical and non clinical aspects of their jobs. All doctors interviewed by CHI who currently work for the trust, including the medical director, who works five sessions in the department of medicine for elderly people, have regular appraisals. Those appraising the work of other doctors have been trained to do so.

Nursing responsibility

6.15 All qualified nurses are personally accountable for their own clinical practice. Their managers are responsible for implementing systems and environments that promote high quality nursing care.

6.16 On each ward, a G grade clinical manager, who reports to a senior H grade nurse, manages the ward nurses. The H grade nurse covers all wards caring for older people and was managed by the general manager for the Fareham and Gosport division. The general manager reported to both the director of nursing and the operations director. An accountability structure such as this is not unusual in a community hospital. The director of nursing was ultimately accountable for the standard of nursing practice within the hospital.

Nursing supervision

6.17 Clinical supervision for nurses was recommended by the United Kingdom Central Council in 1996 and again in the national nursing strategy, *Making a difference*, in 1999. It is a system through which qualified nurses can maintain lifelong development and enhancement of their professional skills through reflection, exploration of practice and identification of issues that need to be addressed. Clinical supervision is not a

7 | Lessons learnt from complaints

7.1 A total of 129 complaints were made regarding the provision of elderly medicine since 1 April 1997. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra hospitals. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

7.2 Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. Three complaints in the last five months of 1998 expressed concern regarding pain management, the use of diamorphine and levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients, was considered by the police expert witnesses.

External review of complaints

7.3 One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical adviser found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 was referred to an independent review panel, which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Although the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

Complaint handling

7.4 The trust had a policy for handling patient related complaints produced in 1997 and reviewed in 2000, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure*. A leaflet for patients detailing the various stages of the complaints procedure was produced, which indicated the right to request an independent review if matters were not satisfactorily resolved together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards during CHI's visit.

GMC100829-0348

4. There was a planned approach to the service development in advance of the change in use of beds in 2000. The increasing dependency of patients and resulting pressure on the service, whilst recognised by the trust, was neither monitored nor reviewed as the changes were implemented and the service developed.

5. Portsmouth Healthcare NHS Trust should be congratulated for its progress towards a culture of reflective nursing practice.

6. The trust has a strong staff focus, with some notable examples of good practice. Despite this, CHI found evidence to suggest that not all staff felt adequately supported during the police and other recent investigations.

7. Out of hours medical cover for the three wards out of hours is problematic and does not reflect current levels of patient dependency.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangemnts, clinical governance responsibilities and trianing needs.

2. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

3. Fareham and Gosport PCT and East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

4. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

5. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

managerial activity, but provides an opportunity to reflect and improve on practice in a non judgemental environment. Clinical supervision is a key factor in professional self regulation.

6.18 The trust has been working to adopt a model of clinical supervision for nurses for a number of years and received initial assistance from the Royal College of Nursing to develop the processes. As part of the trust's clinical nursing development programme, which ran between January 1999 and December 2000, nurses caring for older people were identified to lead the development of clinical supervision on the wards.

6.19 Many of the nurses interviewed valued the principles of reflective practice as a way in which to improve their own skills and care of patients. The H grade senior nurse coordinator post, appointed in November 2000, was a specific trust response to an acknowledged lack of nursing leadership at the Gosport War Memorial Hospital.

Teamworking

6.20 Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. Staff interviewed by CHI spoke of teamwork, although in several instances this was uniprofessional, for example a nursing team. CHI observed a multidisciplinary team meeting on Daedalus ward, which was attended by a consultant, a senior ward nurse, a physiotherapist and an occupational therapist. No junior staff were present. Hospital staff described input from social services as good when available, though this was not always the case.

6.21 Regular ward meetings are held on Sultan and Daedalus wards. Arrangements are less clear on Dryad ward, possibly due to the long term sickness of senior ward staff.

6.22 Arrangements for multidisciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multidisciplinary goal setting for patients, but were hopeful of further development.

Allied health professional structures

6.23 Allied health professionals are a group of staff which include occupational therapists, dieticians, speech and language therapists and physiotherapists. The occupational therapy structure is in transition from a traditional site based service to a defined clinical specialty service (such as stroke rehabilitation) in the locality. Staff explained that this system enables the use of specialist clinical skills and ensures continuity of care of patients, as one occupational therapist follows the patient throughout hospital admission(s) and at home. Occupational therapists talking to CHI described a good supervision structure, with supervision contracts and performance development plans in place.

6.24 Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right through to home treatment. Physiotherapists described good levels of training and supervision and involvement in Daedalus ward's multidisciplinary team meetings.

GMC100829-0349

6.25 Speech and language therapists also reported participation in multidisciplinary team meetings on Daedalus ward. Examples were given to CHI of well developed in service training opportunities and professional development, such as discussion groups and clinical observation groups.

6.26 The staffing structure in dietetics consists of one full time dietitian based at St James Hospital. Each ward has a nurse with lead nutrition responsibilities able to advise colleagues.

Workforce and service planning

6.27 In November 2000, in preparation for the change of use of beds in Dryad and Daedalus wards from continuing care to intermediate care, the trust undertook an undated resource requirement analysis and identified three risk issues:

- consultant cover
- medical risk with a change in patient group and the likelihood of more patients requiring specialist intervention. The trust believed that the introduction of automated defibrillators would go some way to resolve this. The paper also spoke of "the need for clear protocols...within which medical cover can be obtained out of hours"
- the trust identified a course for qualified nursing staff, ALERT, which demonstrates a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration

6.28 Despite this preparation, several members of staff expressed concern to CHI regarding the complex needs of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages and high sickness levels. Concerns were raised formally with the trust in early 2000 around the increased workload and complexity of patients. This was acknowledged in a letter by the medical director. CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix, though a full time staff grade doctor was in post by September 2002 to replace and increase the previous five sessions of clinical assistant cover.

Access to specialist advice

6.29 Older patients are admitted to Gosport War Memorial Hospital with a wide variety of physical and mental health conditions, such as strokes, cancers and dementia. Staff demonstrated good examples of systems in place to access expert opinion and assistance.

6.30 There are supportive links with palliative care consultants, consultant psychiatrists and oncologists. The lead consultant for elderly mental health reported close links with the three wards, with patients either given support on the ward or transfer to an elderly mental health bed. There are plans for a nursing rotation

programme between the elderly medicine and elderly mental health wards. Staff spoke of strong links with the local hospice and Macmillan nurses. Nurses gave recent examples of joint training events with the hospice.

6.31 CHI's audit of recent case notes indicated that robust systems are in place for both specialist medical advice and therapeutic support.

Staff welfare

6.32 Since its creation in 1994, the trust developed as a caring employer, demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy that has won national recognition. The hospital was awarded Investors in People status in 1998. Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship.

6.33 However, many staff, at all levels in the organisation, spoke of the stress and low morale caused by the series of police investigations and the referrals to the General Medical Council, the United Kingdom Central Council and the CHI investigation. Trust managers told CHI they encouraged staff to use the trust's counselling service and support sessions for staff were organised. Not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, "I don't feel I've had the support I should have had before and during the police investigation – others feel the same".

Staff communication

6.34 Most staff interviewed by CHI spoke of good internal communications, and were well informed about the transfer of services to PCTs. The trust used newsletters to inform staff of key developments. An intranet is being developed by the Fareham and Gosport PCT to facilitate communication with staff.

KEY FINDINGS

1. Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards. It was not made clear to CHI how GPs working as clinical assistants and admitting patients to Sultan wards are included in the development of trust procedures and clinical governance arrangements.

2. There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff. Currently, there is effective nursing leadership on Daedalus and Sultan wards, this is less evident on Dryad ward. CHI was concerned regarding the potential for professional isolation of the staff grade doctor.

3. Systems are now in place to ensure that appropriate specialist medical and therapeutic advice is available for patients. Some good progress has been made towards multidisciplinary team working which should be developed.

GMC100829-0350

29/08

GENERAL
MEDICAL
COUNCIL

Protecting patients,
guiding doctors

GMC Case Reference Number: 2002/2047

Name of doctor: Dr J. Barton

Under Section 35A(2)(a)/(b) of the Medical Act 1983 (as amended), you are asked to provide details of your current employment. (Please include employment or arrangements with Health Authorities, locum agencies, hospitals or surgeries and details of bodies outside of the NHS). Failure to comply with the statutory request to provide the above information may result in further proceedings against you:

Name & address of employer	Job title/post
Hampshire and Isle of Wight Practitioner and Patient Services Agency Cottbury House, Friarsgate Winchester Hampshire SO23 8EE	General Practitioner

Cont. over/on separate sheet if neccessary ......

Declaration:

I have provided the GMC with details of my current employment as required by Section 35A(2)(a)/(b) of the Medical Act 1983 (as amended). I confirm that I have given this information truthfully and in good faith.

Name (please print) J. A. BARTON

Signature Code A **Date** 10-07-02

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

In reply please quote: SB/FPD/2000/2047

5 August 2002

The Chief Executive
Hampshire & Isle of Wright
Practitioner & Patient Services Agency
Coithking House, Friarsgate
Winchester
Hampsire SO23 8EE

Dear Sir/Madam

I write pursuant to the provisions of Section 35B(1)(b)(I)/(ii) of the Medical Act 1983 (as amended), to inform you that we have received a complaint about Dr J Barton, who has informed us that he works for Hampshire & Isle of Wight Agency as a GP.

The allegations made against Dr Barton are to be considered by the Council's Preliminary Proceedings Committee, who will decide whether the doctor should be referred to the Professional Conduct Committee on a charge of serious professional misconduct.

The allegations to be considered by the Committee are as follows:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998 Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

b. Your prescribing to Mrs A of opiate and sedative drugs was inappropriate and/or unprofessional in that

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs A was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs A's condition;

3. a. i. On 6 August 1998 Mrs B was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs B from 20 August 1998 until her death the following day

iv. Mrs B had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs B of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which

were excessive and potentially hazardous to a patient in Mrs B's condition

c. Your management of Mrs B was unprofessional in that you failed to pay sufficient regard to Mrs B's rehabilitation needs;

4. a. i. On 11 August 1998 Mrs C was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs C was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs C did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs C artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs C subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs C received no foods or fluids

b. Your prescribing to Mrs C of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs C was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs C pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs C was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs C's condition

c Your management of Mrs C was unprofessional in that you failed to pay sufficient regard to Mrs Cs' rehabilitation needs.;

5. a. i. On 21 September 1998 Mr D was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr D you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr D did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr D's death on 26 September 1998

b. Your prescribing to Mr D of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr D's condition

c. Your management of Mr D was unprofessional in that you failed to pay sufficient regard to Mr D's rehabilitation needs;

6. a. i. On 14 October 1998 Mr E was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr E's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr E via syringe driver from 16 October 1998

b. Your prescribing to Mr E of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr E's condition

c. Your management of Mr E was unprofessional in that you failed to pay sufficient regard to Mr E's rehabilitation needs.

It is intended that the Preliminary Proceedings Committee will consider these allegations at their meeting on **29 August 2002**.

Should the Committee decide that no issue of serious professional misconduct is raised by these allegations, they may conclude the matter by issuing a warning or advisory letter to the doctor about his future conduct, or decide to take no action. We will write to you again after the Committee meeting to inform you of their decision.

We will inform the Department of Health of these allegations. As deliberations at this stage of our procedures are private, I would ask you not to disclose this information to any persons outside your organisation.

Please write personally to acknowledge receipt of this letter.

Yours sincerely

Code A

Sandra Baldwin
Disclosure Officer

Code A

*Protecting patients,
guiding doctors*

Christine Payne Code A

From: Christine Payne (Code A
Sent: 28 Aug 2002 10:24
To: Venessa Carroll (Code A
Subject: RE: Dr Barton

I have spoken to Ian Barker - he is content that CHI report is flagged up as being available to Chairman. I will place on file (Barton has its won box!) own
Christine

-----Original Message-----
From: Venessa Carroll Code A
Sent: 27 Aug 2002 14:44
To: Christine Payne Code A
Subject: RE: Dr Barton

okay. thanks

-----Original Message-----
From: Christine Payne Code A
Sent: 27 Aug 2002 14:37
To: Venessa Carroll Code A
Subject: Dr Barton

Venessa
This case is in PPC day 1. CHI have prepared a report which has just been sent to us. It does not name Dr Barton specifically but refers to the criminal investigations and criticises systems in place at the time. I have a call out to Ian Barker at MDU to see if he wishes for report to be made available to PPC; if not it can be on file but I am not sure how necessary it is for PPC to know about it - it could be flagged up to Chairman though.
Christine

29-30 Aug

Please quote our reference when communicating with us about this matter

THE 1
MDU
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ
Code A
Lambeth

Legal Department of The MDU

Freephone: 0800
Telephone: 020 7202 1500
Fax: 020 7202 1663
Code A
Website www.the-mdu.com

.ur ref: ISPB/TOC/9900079/Legal
Your ref: 2000/2047
27th August 2002

FAO: Lorna Johnston
General Medical Council
178 Great Portland Street
London, W1

Also by fax: 0207-915-3696

Dear Madam

Re: Dr Jane Barton

I act for Dr Jane Barton, and write with reference to the letter to her from Mr Leighton of 11th July 2002. I would be grateful if this letter could be placed before the Preliminary Proceedings Committee meets to consider this matter on 29th – 30th August, representing Dr Barton's response in relation to the various matters raised in Mr Leighton's letter.

It may be of assistance to the Committee to have some general information at the outset about Dr Barton, the Gosport War Memorial Hospital and in particular about the working environment in which Dr Barton had to practice at the Hospital at the relevant time in 1998. Dr Barton's case was in fact considered by the Interim Orders Committee in March this year. At that time the Committee determined that it was not satisfied it was necessary to make any order affecting Dr Barton's registration. Dr Barton gave evidence on oath before the Committee, which evidence dealt very much with these matters. It may therefore be of considerable assistance for the Committee to have access to Dr Barton's evidence then, and I have pleasure in enclosing a copy of the transcript of the proceedings on the 21st March from pages 5 to 23. The initial pages of the transcript involve representations from Counsel instructed for the GMC, raising issues within the expert reports to which the PPC already has access.

It may nonetheless be helpful for the Committee to have brief further review of Dr Barton's position here. Dr Barton qualified in 1972. She entered General Practice in 1976, joining her present practice in 1980, where she has practised in partnership on a minimum full-time basis. From 1996 to 1998 Dr Barton was a locality Commissioner, seconded to the Health Authority to assist in relation to purchasing issues, and from 1998 to 2000 she was the Chair of the local Primary Care Group.

In addition to her general practice duties, Dr Barton took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial Hospital, a cottage hospital, in 1988. As the Committee will appreciate, the position of Clinical Assistant is a training post, and for Dr Barton it was a part-time appointment. Initially the position was for 4 sessions each week, one of which was allocated to Dr Barton's partners to provide out of hours cover. This was later increased, so that by 1988 the Health Care Trust had allocated Dr Barton 5 clinical assistant sessions, of which 1 ½ were now given

to her partners in her practice for the out of hours aspects of the post. Dr Barton was therefore expected to carry out her day to day responsibilities in this post in effect within 3 ½ sessions each week.

Dr Barton worked on two of the wards at the Hospital, Daedalus, and Dryad Wards. The two wards had a total of 48 beds. About 8 of the beds on Daedalus Ward were for 'slow stream' stroke patients. The remaining beds were otherwise designated to provide continuing care for elderly patients.

Two Consultants in elderly medicine were response for each of the wards. Dr Althea Lord was responsible for Daedalus Ward and Dr Jane Tandy for Dryad Ward. Both Consultants, however, had considerable responsibilities elsewhere and thus their actual time at the Gosport War Memorial Hospital was significantly limited. Dr Lord for example was responsible for an acute ward and a continuing care ward at the Queen Alexandra Hospital in Portsmouth, and had responsibilities at a third site, St Mary's Hospital, also in Portsmouth. As a result, Dr Lord's presence at the hospital was limited to conducting a continuing care ward round on Daedalus Ward every other Monday. She would also be in the hospital, conducting outpatients on Thursday when she would carry out a further ward round in relation to the stroke patients.

Dr Tandy took annual leave towards the end of April 1998 followed immediately thereafter by maternity leave, so that she did not return to work until February 1999. The Trust took the decision that her post should not be filled by a locum. Dr Lord kindly volunteered to make herself available to cover, but the reality was that given her own position as a very busy consultant, she could not carry out a ward round on Dryad Ward. The Committee will appreciate therefore that for much of the relevant period in 1998 with which it is concerned, Dr Barton had no effective consultant support on one of the two wards for which she had responsibilities, with the consultant role on the other ward already being limited.

Dr Barton would arrive at the Hospital each morning when it opened about 7.30am. She would visit both wards, reviewing patients and liasing with staff, before she then commenced her General Practitioner responsibilities at 9am. She would return to the Hospital virtually every lunchtime. New patients, of whom there were about 5 each week, would usually arrive before lunchtime and she would admit patients, write up charts and see relatives. Quite often, in particular if she was the duty doctor, Dr Barton would return to the Hospital after GP surgery hours at about 7pm. She was concerned to make herself available to relatives who were not usually able to see her in the course of their working day. She would attend the Daedalus ward round on Mondays with Dr Lord, but was unable to attend the round for stroke patients on Thursdays.

Further, Dr Barton was concerned to make herself available even outside those hours when she was in attendance at the hospital. The nursing staff would therefore ring her either at her home or at her GP surgery to discuss developments or problems with particular patients. In the event that medicine was to be increased, even within a range of medication already prescribed Dr Barton it would be usual for the nursing staff either to inform Dr Barton of the fact that they considered it necessary to make such a change, or would inform her shortly thereafter of the fact that that increase had been instituted.

When Dr Barton first took up her post as clinical assistant the level of dependency of patients was relatively low. In general the patients did not have major medical needs. However, over time that position changed greatly. Patients who were increasingly dependent would be admitted to the wards, so that in time, and certainly by 1998, many of the patients were profoundly dependent with minimal Bartell scores. There was in consequence a considerable increase in the medical and nursing input required to care for such patients.

Further, at the relevant time the bed occupancy was about 80%. That was then to rise to approximately 90%. There would therefore be as many as 40 or more patients to be seen and/or reviewed by Dr Barton when she attended each day.

As the Committee might anticipate over the 10 years in which she was in post, Dr Barton was able to establish a very good working relationship with the nursing staff at the hospital. She found them to be responsible and caring. They were experienced, as indeed Dr Barton herself became, in caring for elderly dependent patients. Dr Barton felt able to place a significant measure of trust in the nursing staff.

Over the period in which Dr Barton was in post there was no effective increase in the numbers of nursing staff. With the significant number of patients and the considerable increase in dependency over the period, the nurses, like Dr Barton, were faced with an excessive workload.

The picture therefore that emerges by 1998 at this cottage hospital is one in which there had been a marked increase in the dependency of the patients, and indeed an increase in their numbers. There was limited consultant input, reduced still further by the fact that no locum was appointed to cover Dr Tandy's position. By this time the demands on Dr Barton were considerable indeed given that she was expected to deliver this significant volume of care within a mere 3 ½ sessions each week. As the Committee will appreciate from Dr Barton's evidence to the Interim Orders Committee, she raised this matter with management, albeit verbally, saying that she could not manage this level of care for the number of patients, but the reality was that there was no one else to do it. In due course Dr Barton felt unable to continue. She resigned from her post in 2000.

The Committee may feel it is of some significance that her position was then replaced, not with another part-time clinical assistant, but a full-time staff grade. Indeed, Dr Barton's present understanding is that this post may be increased to two full-time positions, and is a clear reflection of the very considerable demands upon her at the relevant time when she was struggling to cope with the care of patients. In addition, the Consultant cover to the two wards was increased to ten sessions per week in 2000. In 1998, Dr Barton had tried to raise the issue and could have walked away, resigning her position at that time. However, she felt obliged to remain, to support her colleagues, and more particularly, to care for her patients. In reality she was trying to do her best in the most trying of circumstances.

For Dr Barton caring for patients on a day by day basis therefore she was left with the choice of attending to her patients and making notes as best she could, or making more detailed notes about those she did see, but potentially neglecting others. In the circumstances, Dr Barton attended to her patients and readily accepts that her note

keeping suffered in consequence. The medical records therefore do not set out each and every review with a full assessment of a condition of a patient at any given point.

Similarly, in relation to prescribing Dr Barton felt obliged to adopt a policy of pro-active prescribing, giving nurses a degree of discretion and administering within a range of medication. As a result, if the patient's condition deteriorated such that they required further medication to ease pain and suffering, that medication could be given even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient. This was of assistance in particular out of hours. It was a practice adopted out of necessity, but one of which Dr Barton had trust and confidence in the nurses who would be acting on her prescripts, and indeed in which the nurses would routinely liase with her as and when increases in medication were made even within the authority of the prescription.

The Committee may feel that it is also of some significance that prescriptions of this nature by Dr Barton were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was Dr Barton ever informed that her practice in this regard was inappropriate.

Lest this observation, and indeed others, in relation to the degree of consultant support appear in any way to be critical of Dr Lord, Dr Barton is anxious to emphasise the evidence which she gave at the Interim Orders Committee in this regard – that Dr Lord was caring, thoughtful and considerate. The reality is that Dr Lord too had a considerable workload, and she did what she could given the constraints upon her.

Professor Ford comments in his report that there may have been inadequate senior medical input into the wards and that it would be important to examine this in detail. It does not appear from this that Professor Ford, or indeed the other experts, were informed by the police of the levels of nursing and medical staffing on the two wards in question. Such information would be of particular importance in evaluating properly any perceived failings on the part of 'junior medical staff' - Dr Barton. Indeed, as the committee will see from the questioning and responses on page 13 of the transcript of the IOC hearing, it may even be the case that Professor Ford was unaware that Dr Barton was the only member of the "non-consultant medical staff" and that she was part time at that.

It was in this context then that Dr Barton came to treat and care for the patients in question, and the committee will no doubt wish to consider that context carefully. With reference to the patients the committee may be further assisted by the following information:

Eva Page

Mrs Page was admitted to the Victory ward of the Queen Alexandra Hospital on 6th February 1998 suffering with anorexia, cachexia, depression and a 2 inch mass in her left hilum which was diagnosed on chest x ray as lung cancer. She had a history of heart failure and was receiving medication accordingly. It was felt that she was too ill to undergo bronchoscopy by way of further examination and on 12th February it was noted that she should receive palliative care and was not for resuscitation.

On 16th February she was noted to be confused and deteriorating gradually. She was later transferred to Charles ward, a palliative care ward at Queen Alexandra Hospital, and from time to time was noted to be confused, frightened and calling out.

On 25th February Mrs Page was seen by Dr Lord who stopped all medication and commenced Thioridazine, before she was then admitted to the Gosport War Memorial Hospital 2 days later. Dr Barton saw her the same day, clerking her in and assessing her condition. By this stage Mrs Page was totally dependent with a Bartell score of zero. Dr Barton reviewed the notes from the Queen Alexandra Hospital and was aware of the assessments which had been made, including that relating to palliative care.

Dr Barton prescribed Thioridazine and Oramorph on an 'as required' basis. Although she was not in pain at the time, Dr Barton appreciated that given the diagnosis of lung cancer, pain relief with opiates might become necessary. Mrs Page was clearly very ill. In Dr Barton's view she was indeed in terminal decline as others had assessed her to be. Dr Barton recorded in the notes that she was happy for the nurses to confirm death.

It was Dr Barton's practice to record this in a patient's notes if it was felt that the patient was likely to die. This in no way reflected the nature or quality of care to be given to a patient. If a patient died unexpectedly, the nursing staff would be required to call out a duty doctor, there usually being no medical presence at the hospital. If a death was not unexpected - recorded by Dr Barton in this way - Dr Barton was content the nurses should confirm death in the first instance, with Dr Barton or Dr Lord to certify death when next available at the hospital.

In any event, the following day Mrs Page was noted by the nursing staff to be very distressed, calling out for help and saying that she was afraid. Thioridazine was given, but with no effect and it appears to have become necessary to call out the duty doctor.

By 2nd March it seems that Mrs Page was now also in pain. She was assessed by Dr Barton in the morning, who recorded that there had been no improvement on major tranquillisers and she suggested adequate opioids to control Mrs Page's fear and pain. Dr Barton prescribed a Fentanyl patch which would have the effect of a continuous delivery, but which can take some time to be effective. To cover the intervening period, Dr Barton also prescribed 5mgs of Diamorphine intramuscularly, to be given then, with a further 5mgs at 3pm.

From the records it is clear that Dr Lord saw the patient later that day and was aware of the medication which had been given. Dr Lord made two entries in the notes, and in the second she recorded that she had spoken with Mrs Page's son. It is apparent from the note that there had been a further deterioration in Mrs Page's condition and that Dr Lord believed she was dying.

Dr Barton was concerned that Mrs Page might require medication via a syringe driver as a more effective way of alleviating her pain and distress. She prescribed Diamorphine in a 20 - 200mgs/24 hours range as required, together with Hyoscine and Midazolam for subcutaneous delivery. On 3rd March, before the syringe driver was set up by the nursing staff, Mrs Page was noted to have deteriorated still further, and a left sided CVA was

suspected. Midazolam and 20mgs of Diamorphine to be delivered over 24 hours was commenced by syringe driver at 10.50 that morning. That would be the equivalent of the 60mgs of Oramorph she had received in the previous 24 hours. Mrs Page died peacefully at 9.30 that night.

Alice Wilkie

Mrs Wilkie was admitted to the Queen Alexandra Hospital on 31st July 1998 with a history of severe dementia. Her Bartel score was recorded at 1. She was reviewed again on 1st August and the clinician attending her then considered her condition was such that she should not be resuscitated in the event of emergency. She was seen by Dr Lord on 4th August who recorded that her overall prognosis was poor and confirmed that she should not be resuscitated. The plan was for Mrs Wilkie to be admitted to the Gosport War Memorial Hospital for observation.

That transfer took place on 6th August, and Mrs Wilkie was seen initially By Dr Peters, one of Dr Barton's partners, Dr Barton being on sick leave at the time. Dr Lord assessed Mrs Wilkie again on 10th August, recording that her Bartel score was now 2, confirming that she was profoundly dependent.

The nursing records contain no entries for the period 6th August - 17th August, suggesting that this was a time when the staff were profoundly stretched, but on 17th August Mrs Wilkie was noted to have deteriorated over the weekend and that her condition was worsening, from a state which had already been poor.

Dr Barton believes that she saw the patient on 20th August. Although she has not made an entry in Mrs Wilkie's notes, a prescription of subcutaneous Diamorphine - 20 - 200mgsover 24 hours, together with Midazolam and Hyoscine is recorded. 30mgs of Diamorphine over 24 hours with 20mgs of Midazolam was commenced at 1.30 that afternoon, via syringe driver.

Dr Barton saw Mrs Wilkie the following morning, noting the marked deterioration over the past few days and that subcutaneous medication had been commenced. A nursing entry shortly before 1.00 that afternoon recorded that Mrs Wilkie's condition had deteriorated during the morning but she was said to be comfortable and free from pain. Mrs Wilkie died later that day at 6.00pm.

Mrs Gladys Richards

Dr Barton has of course made a lengthy statement concerning the treatment of Mrs Richards, contained in the Committee's papers at pages 153 - 163. The Committee will no doubt consider that statement in detail, being Dr Barton's explanation.

Arthur Cunningham

Mr Cunningham, who suffered from Parkinson's disease and depression, was admitted to the Gosport War Memorial Hospital on 21st September 1998, having been reviewed that day at the Dolphin Day Hospital by Dr Lord. As Dr Lord recorded in her letter to Mr

Cunningham's GP dictated the same day, Mr Cunningham had a large necrotic sacral ulcer which was extremely offensive. Dr Lord stated that he continued to be very frail.

In her notes in the hospital records, Dr Lord confirmed this, stating that the prognosis was poor and that Mr Cunningham should have 5 - 10mgs of Oramorph if he was in pain. 5mgs of Oramorph was then given at 2.50pm.

Dr Barton saw Mr Cunningham on 21st September, after his admission, and noted that he should have adequate analgesia. She was aware of Dr Lord's view of the poor prognosis and, agreeing with that assessment, Dr Barton recorded that she was happy for the nursing staff to record death.

The notes contain photographs of the sacral sore at the time of Mr Cunningham's admission, which are far from clear in the photocopies of the medical records now available. Dr Barton recalls, however, that it was about the size of a fist. Concerned that Mr Cunningham might require further pain relief in due course, through increasing pain and tolerance, Dr Barton prescribed Diamorphine - 20 - 200mgs, Midazolam 20 - 80mgs and Hyoscine over 24 hours subcutaneously, to ensure a continuous delivery of pain relief and that there would be no breakthrough pain.

A further dose of Oramorph was given at 8.15pm, but the nursing records show that Mr Cunningham appears to have remained in pain and required assistance to settle for the night. The syringe driver was commenced at 11.10 that night, delivering 20mgs of Diamorphine and 20mgs of Midazolam, following which Mr Cunningham slept soundly. He was noted to be much calmer the following morning.

Dr Barton would have seen Mr Cunningham each day. On 23rd September the nursing notes record that Mr Cunningham had become chesty and Hyoscine was added to dry the secretions on his chest. The records make clear the view that by this stage Mr Cunningham was dying. At 8pm on 23rd September the Midazolam was increased to 60mgs to maintain Mr Cunningham's comfort.

On 24th September Dr Barton noted that Mr Cunningham's pain was being controlled by the analgesia - just. The nursing records show that the night staff had reported Mr Cunningham was in pain when being attended to, and the day staff also noted pain. The Diamorphine was increased to 40mgs and the Midazolam to 80mgs accordingly. Mr Cunningham was then noted by the nurses to have a peaceful night.

The following day Mr Cunningham was seen by Dr Brooks, one of Dr Barton's partners, who confirmed that Mr Cunningham remained very poorly. Dr Barton also saw Mr Cunningham that day, writing up a prescription for Diamorphine for 40 - 200mgs, Midazolam at 20 - 200mgs, together with Hyoscine. In fact it was necessary to administer 60mgsof Diamorphine and 80mgs ofMidazolam/24 hours via the syringe driver in order to control the pain.

The following day, 26th September, Mr Cunningham's condition continued to deteriorate slowly. Diamorphine was increased to 80mgsover 24 hours, and the Midazolam to 100mgs to control the pain. Mr Cunningham then died peacefully at 11.15 that evening.

Our ref: ISPB/TOC/9900079/Legal
Your ref: 2000/2047
27th August 2002

Robert Wilson

Mr Wilson was admitted to the Queen Alexandra Hospital on 21st September 1998 with a fracture of the humerus. He had a history of alcohol abuse and heart failure, for which he was receiving medication. X ray revealed displacement, but Mr Wilson was unwilling to undergo surgery. He was in pain, receiving a range of painkillers, including opiates in the form of Morphine and Diamorphine.

On 29th September it was noted that resuscitation was considered inappropriate in view of the poor quality of life and the poor prognosis. On 8th October he was assessed by a psychogeriatrician who said that he was in low mood, presenting with a wish to die and disturbed sleep, possibly secondary to pain. She diagnosed early dementia, possibly alcohol related, and depression.

A decision was then made to transfer Mr Wilson to the Gosport War Memorial Hospital and Dr Barton clerked him in following his arrival on 14th October. Dr Barton noted the plan as gentle mobilisation. She believes Mr Wilson was in a degree of pain following his transfer, and she prescribed Oramorph in addition to Paracetamol on an 'as required' basis. Oramorph was given for pain relief at 2.45pm and 11.45pm on 14th October.

Dr Barton wrote a further prescription for Oramorph on 15th October, for 10mgs 4 hourly and 20mgs at night to control the pain in Mr Wilson's arm, which persisted. As a result of that Oramorph, Mr Wilson was noted to have settled and slept well.

Later that night Mr Wilson appears to have suffered what was thought to have been a silent myocardial infarction. Dr Knapman was called to see him on 16th October, and he increased the dose of Frusemide Mr Wilson was already receiving for his pre-existing heart failure. Dr Knapman noted a decline overnight with a shortness of breath, bubbling, and a week pulse. He had significant oedema in the arms and legs, and was unresponsive to the spoken word.

Dr Barton believes she may have come in to see Mr Wilson later in the day. The nursing record for 15th October had noted that Mr Wilson had difficulty in swallowing, and as he would have had difficulty in taking Oramorph, Dr Barton decided in view of his condition now that he should receive pain relief subcutaneously, converting to Diamorphine via syringe driver. She prescribed 20 - 200mgs of Diamorphine, 20 - 80mgs of Midazolam, together with Hyoscine for the chest secretions. The Diamorphine was then commenced at 20mgs over 24 hours, entirely consistent with the 60mgsofOramorph which had been required for pain relief the previous day. As a result, the nursing records show that after the Diamorphine was commenced, Mr Wilson had not been distressed and appeared comfortable.

On 17th October Dr Peters was called to see Mr Wilson. Dr Peters noted that he was comfortable, though he had deteriorated. Dr Peters also recorded that the nursing staff should verify death if necessary. Later that day the Diamorphine was increased to 40mgs over 24 hours and Midazolam added at 20mgs/24 hours. Mr Wilson was producing significant secretions, requiring suctioning, apparently being in heart failure, and the Hyoscine was also increased. In consequence, the secretions were noted not to disturb him, and he appeared to be comfortable.

The following day he was seen again by Dr Peters. The nurses noted that there had been a further deterioration in his already poor condition. The syringe driver was reviewed at 2.50 that afternoon, and the Diamorphine increased to 60mgs and the Midazolam to 40mgs. Mr Wilson continued to require regular suctioning and Dr Peters prescribed a further increase in the Hyoscine.

Mr Wilson continued to deteriorate in the course of the afternoon, and he died peacefully that night at 11.40pm.

Summary

Dr Barton endeavoured to care for her patients in what were clearly very difficult circumstances. She did not wish to abandon her consultant, her nursing colleagues and the patients. She raised her concerns with management, but to no avail. The information above about the individual patients will hopefully assist the Committee in considering this matter, coupled most importantly with an understanding of the situation in which Dr Barton found herself. I respectfully suggest that the Committee can reasonably conclude that this is not essentially a matter of professional conduct, but rather an issue of lack of resources and proper management.

Yours faithfully

Ian S P Barker
Solicitor

PPC hears

A

THE CHAIRMAN: The working relationship between Dr Lord and Dr Barton might be explored through Mr Jenkins.

In the absence of further questions, Mr Jenkins, would you like to begin?

MR JENKINS: Sir, what I propose to do is ask Dr Barton to give evidence before you.

B

JANE ANN BARTON, Sworn
Examined by MR JENKINS

Q Dr Barton, 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.

C

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 clinical assistant 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?

D

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.

E

A The health care trust allocated me five clinical assistant 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 clinical assistant 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.

F

G

Dryad ward had no consultant cover for the 10 months that you are considering these cases. Dr Lord 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?

H

A Yes.

A

THE CHAIRMAN: The working relationship between Dr Lord and Dr Barton might be explored through Mr Jenkins.

In the absence of further questions, Mr Jenkins, would you like to begin?

MR JENKINS: Sir, what I propose to do is ask Dr Barton to give evidence before you.

B

JANE ANN BARTON, Sworn
Examined by MR JENKINS

Q Dr Barton, 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.

C

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 clinical assistant 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?

D

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.

E

A The health care trust allocated me five clinical assistant 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 clinical assistant 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.

F

G

Dryad ward had no consultant cover for the 10 months that you are considering these cases. Dr Lord 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?

H

A Yes.

A

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.

B

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.

C

Q How many other doctors would be there throughout the day to treat these 48 patients if all the beds were full?
A None.

D

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.

E

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.

F

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.

G

H

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

A

Q Tell us how.

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.

B

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.

C

Q That is an indication of the requirements made of nursing staff?

A Nursing requirements. They could not do anything for themselves, basically.

D

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 Althea was left to attempt to help me with both, although she was not officially in charge.

E

Q Althea is...?

A Dr Lord, the other consultant.

F

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.

G

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.

H

A

Q You have told us that over a 10-month period there was no consultant 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.

B

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.

C

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.

D

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.

E

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.

F

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

G

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----

H

A

Q Is that 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.

B

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.

C

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, chairman 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 clinical assistant, 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.

D

E

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.

F

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.

G

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

H

A

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.

B

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.

D

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 acting clinical director 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.

E

F

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.

G

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

H

A comment on how much input the Trust put into improving their skills. I think that would be inappropriate for me to do.

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?

B

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.

D

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.

E

F

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.

G

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.

H

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.

A

Q What we see again and again in the comments of Professor Ford 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 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.

B

Q I will ask you to turn to page 370, which is the final couple of paragraphs of Professor Ford'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".

D

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.

E

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".

F

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

G

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

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

H

Q ...in the cottage hospital.
A No.

T A Reed
& Co

A

Q It may be that Professor Ford believed that you were permanent staff.
A Failed junior staff! His last comment in paragraph 7.5 – his review of Dr Lord'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.

B

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 Professor Ford's next paragraph. He says,

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

– 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?

D

A I find it very upsetting. I was only a clinical assistant. 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 acting chief executive, Dr Old. Yes?

E

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?

F

A Yes.

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

G

Q Had you not agreed those, were you threatened with any action?
A Dr Old 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.

H

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.

THE CHAIRMAN: We will refer to it as D1. [*Same handed*]

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

THE CHAIRMAN: I assume they have been circulated. Shall we put them in chronological order?

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

A

> "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,

B

> "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".

C

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...",

D

and the other matters that you see listed.

The next document is a letter from Dr Barton dated 22 February to Dr Jarrett. The letter reads,

E

> "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 consultant or seamless locum consultant cover for a period of a further month on one of the wards, and the other consultant cannot be expected to provide anything other than firefighting support during this time.
>
> As a result, I am unable to do the clinical assistant 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

F

G

H

A

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".

B

The next document in time is a letter from Dr Jarrett dated 7 March, by way of response. I do not need to read it to you, but you have heard Dr Barton suggest 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 Dr Barton dated 28 April 2000, tendering her resignation. It is addressed to Peter King, personnel director, 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.

D

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 consultant 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.

E

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.

F

The last letter, dated 19 May from Fiona Cameron, 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".

G

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

H

THE CHAIRMAN: Mr Lloyd, do you wish to ask questions?

A

THE LEGAL ASSESSOR: I have no questions, sir.

Questioned by the COMMITTEE

DR RANSON: Did you have consultant cover during 1998?
A I had a lady called Dr Jane Tandy, who became pregnant, who commenced her annual leave on 27 April 1998 and followed on with maternity leave from 1 June until 8 February 1999. So basically she was very pregnant, and then she was gone for the rest of the year.

B

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.

MR WARDELL: 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!

D

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.

E

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.

F

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.

G

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

H

Q Was that your total involvement with the hospital?

T A Reed & Co

A

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.

B

Q Mr Jenkins 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".

C

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.

D

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?

E

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.

F

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.

G

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.

H

MR WINTER: 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

A

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.

B

Dr Lord 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.

C

Q Could you say approximately how many times you raised these matters with people in lower management?

A Once every couple of months.

D

THE CHAIRMAN: 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.

E

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.

F

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.

G

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

H

A

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.

B

Q We are aware of how the Gladys Richards 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? [*Dr Barton conferred with counsel*]

MR JENKINS: Sir, you will recall from what I said to an earlier constitution of this Committee that the relatives of Gladys Richards 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.

D

DR BARTON: 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.

E

THE CHAIRMAN: Technically, as a clinical assistant 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.

F

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.

G

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.

H

Q Were there any audit meetings in the hospital?
A I did not go. I was not invited to go to audit meetings.

A

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 clinical assistant 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.

B

C

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?

D

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

THE CHAIRMAN: 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, Mr Jenkins?

E

MR JENKINS: There is one, sir, and it was raised by Mr Lloyd. Do you have any private patients?
A No.

MR JENKINS: 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.

F

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 Dr Barton'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 Professor Ford and the other doctors that they were well aware that Dr Barton 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.

G

H

A

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? Dr Barton 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.

B

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.

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 Dr Barton'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.

D

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 Dr Barton has voluntarily agreed with the health authority.

E

Those are the submissions that I make.

THE CHAIRMAN: I now turn to the legal assessor.

F

THE LEGAL ASSESSOR: 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.

G

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

MR JENKINS: Sir, I have mentioned the little green book with which Dr Barton has helped. I leave it with you.

H

THE CHAIRMAN: Thank you.

A

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

The parties having been readmitted:

B

THE CHAIRMAN: Dr Barton, 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 under Section 41A of the Medical Act 1983 as amended should be made in relation to your registration.

D

E

F

G

H

29 + 30 Aug.

Mr G Leighton Assistant Registrar
Fitness to Practise Directorate
General Medical Council
178,Great Portland St
London W1W 5JE

Dr J Barton
Code A

Reference 2000/2047

18th July 2002

Dear Mr Leighton

This is to acknowledge receipt of your letter of 11th July 2002.

Yours Sincerely

Code A

Dr Jane Barton

Dr Jane Barton (2000/2047)
(Interested Parties)

Dr Jane Barton Code A
Code A

Ian Barker
MDU Services Ltd, 230 Blackfriars Road, London SE1 8PJ

Dr Peter Old
Acting Chief Executive, Isle of Wight, Portsmouth & South East Hampshire Health Authority, Finchdean House, Milton Road, Portsmouth PO3 6DP

Det Supt John James
Hampshire Constabulary, Major Incident Complex, Kingston Crescent, North End, Portsmouth PO2 8BU

Dr Ian Reid
Department of Elderly Medicine, South Block, Queen Alexandra Hospital, Portsmouth PO6 3LY

Mr Bernard Page (son of Eva Page) Code A
Code A

Mr Iain Wilson (son of Robert Wilson) Code A
Code A

Mrs Gillian MacKenzie (daughter of Gladys Richards) Code A
Code A

Mr C R S Farthing (step son of Arthur Cunningham) Code A
Code A

Mrs M Jackson (daughter of Alice Wilkie) Code A
Code A

TO NOTE FOR FILE

Christine Payne Code A

From: Michael Hudspith Code A
Sent: 07 Aug 2002 13:45
To: Christine Payne Code A
Subject: Dr Jane Barton (PPC 29/08/02)

Christine

Please see message below for information. Mrs McKenzie is the daughter of Gladys Richards, one of the patients whose death we are looking into. Her contact details are on the case file.

Should the case proceed to PCC our solicitors may wish to be aware of other possible complaints with a view to possibly adding these in.

Mrs McKenzie has also requested that when looking at the case the PPC also be asked to consider referring the matter back to the police and ask them to re-open their investigation. I have informed Mrs McKenzie that I have never heard this done and was not sure that it would even be appropriate in this case as

1) the information came from the police in the first place and they have already deceided (on advice from CPS) not to bring charges

2) the CPS's area of expertise is criminal law and ours is professional conduct and performance. It is not our place to advise or suggest to the CPS that their original decision was flawed and should be revisited.

Hope this is clear. Any questions please ask.

Mike

-----Original Message-----
From: Seaton Giles Code A
Sent: 30 Jul 2002 11:42
To: Michael Hudspith Code A
Subject: Phone call

For info:

Gillian McKenzie called re: Dr Barton & Gosport War Memorial Hospital. She wished to inform us that the Deputy Chief Constable of Hants Police was seeking further advice from the CPS regarding the investigation into Dr Barton's actions. She also stated that following publicity, she is now aware of a further 6 cases.

Thanks

Seaton

Hampshire and Isle of Wight
Practitioner & Patient Services Agency

Coitbury House
Friarsgate
Winchester
Hampshire
S023 8EE

Tel: 01962 853361
Fax: 01962 840773
url: www.hiow.ns.uk
e mail Code A
direct dial telephone Code A

CONFIDENTIAL
Sandra Baldwin
Disclosure Officer
General Medical Council
178 Great Portland Street
London
W1W 5JE

15 August 2002
Your ref SB/FPD/2000/2047

Dear Ms Baldwin

I refer to your letter dated 5 August 2002 received today regarding Dr J Barton.

As this Agency works on behalf of PCTs across Hampshire and the Isle of Wight, I have forwarded a copy of your letter to Mr Ian Piper, Chief Executive, Fareham and Gosport PCT as it is the PCT responsible for the provision of primary care in the area that Dr Barton practices.

Yours sincerely

Code A

Manda Copage
General Manager

Cc: Ian Piper, Chief Executive, Fareham and Gosport PCT

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Police Headquarters
West Hill
Romsey Road
WINCHESTER
Hampshire
SO22 5DB

Our Ref. : Chief Supt/JJ/DM
Your Ref. :

Tel. : 0845 045 45 45
Direct Dial :
Fax. : 01962 871 244

29th July 2002

Mr M Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Mr Hudspith

Re: Dr Jane Ann BARTON Code A

Thank you for your letter of the 11th July concerning the above named which I have seen on my return from holiday.

I note the private nature of the current proceedings and await an update in due course. Would you please note that I have moved to a new position and can be contacted in future at the address on this letterhead.

Yours sincerely

Code A

J JAMES
Chief Superintendent

CRIMESTOPPERS 0800 555 111

Isle of Wight, Portsmouth and South East Hampshire NHS
Health Authority

Finchdean House
Milton Road
Portsmouth PO3 6DP

Tel: 023 9283 8340
Fax: 023 9273 3292

Direct Line Code A
Direct Fax

Our Ref: PO/JD/031502jb.doc

15 March 2002

Private & Confidential
Dr Jane Barton

Code A

Dear ~~Dr Barton~~ Jane

I wrote to you on 13 February 2002 setting out our agreement on restrictions to your medical practice. At that time it was not possible to put a timescale on these restrictions, but we agreed to review the situation monthly.

I understand that you are due to appear before the GMC in the very near future. Therefore I propose that we continue with the current restrictions until we have the result of the GMC's deliberations.

Thank you for your continued co-operation.

Yours sincerely

Code A

Dr Peter Old
Acting Chief Executive
Email Address: Code A

cc: Michael Hudspith, GMC

Portsmouth HealthCare NHS
NHS Trust

Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
Portsmouth
Hants
PO6 3LY

Tel 023 9228 6000
Fax 023 9220 0381

Detective Superintendent John James
Major Incident Room
Hampshire Constabulary
Kingston Crescent
Portsmouth

08 March 2002

RIR/cmp

Dear Superintendent James

Further to you letter of 5th February 2002, to Mr Millett regarding Police enquiries at Gosport War Memorial Hospital and our subsequent discussion, we are considering within the Trust what further appropriate action we need to take as the employer of the staff named in the three reports commissioned by the Police.

In the course of this we have identified several inaccuracies in the text of one of the reports (that from Professor Ford). I am quite sure that these are to do with a misreading of the draft when finally being typed up, but given that the GMC and UKCC, along with ourselves, are considering individual staff on the basis of these reports, I felt that I should write highlighting the points so that they can be corrected:

- **Page 17, paragraph 3.13, fourth sentence**

  This reads "poor assessment by Dr. Lord"

  However in view of the subsequent sentence (which reads that "the assessment by Dr Lord was thorough and competent") and of the context of the patient's medical notes (where there is a comprehensive note by Dr Lord but only four lines by Dr Barton), we assume that this should read "poor assessment by Dr Barton".

- **Page 21, paragraph 4.1, line seven**

  This reads "... she is not refusing fluids ..."

  The G.P. letter referred to states "... she is now refusing fluids".

- **Page 26, paragraph 5.5**

GMC100829-0395

C.H.I.

v.

UNKNOWN

30911/2002

30911/2002

COUNCIL

Consideration by the Registrar: to determine whether enquiry is a complaint

Completed by the Office

FPO enquiry reference ☐☐☐☐☐☐☐☐☐☐

Date ☐☐☐☐☐☐ D D M M Y Y

Dr's name† ....

1.1 Is the enquiry about a doctor?

Yes ☐ → *Q1.2*
No ☐ → *Q1.9a*

1.2 Has the doctor been charged or convicted?

Yes ☐ → *Q1.3*
No ☐ → *Q1.4*

1.3 Is the offence a minor motoring offence not involving drugs or alcohol?

Yes ☐ → *Q1.9a*
No ☐ → *Section 3*

1.4 Is the enquiry only about the following?

If multiple options apply, only tick the box for the main option

a. Concerning fees charged for private treatment/service ☐

b. Delay of less than six months in providing a single medical report ☐

c. The doctor's profession is incidental to the matter, e.g. a dispute between neighbours, one of whom happens to be a doctor ☐

d. Objections to the contents of medical reports or records where there is no suggestion that the doctor acted unreasonably ☐

e. Irrational / incoherent enquiry ☐

f. Patently frivolous/trivial non-clinical matters, e.g. doctor a few minutes late for a routine appointment ☐

g. Doctor failed to take up a post following a verbal agreement to do so, but gave two weeks' notice or more ☐

h. A complaint from a third party where it is clear that the principal party does not want to pursue the matter, and no other reason for proceeding ☐

i. A doctor's immigration status ☐

j. The level or quality of service provided by a healthcare organisation where there is no suggestion that the doctor is directly responsible ☐

k. Removal from a GP list where there is no suggestion that the doctor's decision was unfair or contravened GMC guidelines ☐

l. Practice or Departmental disputes where there is no suggestion that patients are being put at risk ☐

m. Failures in local complaints handling procedures ☐

n. Correspondence is a copy letter which does not specifically request GMC action ☐

If any ticks here go to Q1.9a

... there is no reason to suspect that the doctor is an immediate threat to patients ☐ } Q.1.9a

No, none of these ☐ → Q.1.5

1.5 Is the enquiry from a person acting in a public capacity (or on their behalf)?

Yes ☐ → Section 2
No ☐ → Q1.6

1.6 Is the enquiry about any of the following?
If multiple options apply tick the box for the main option

a. a doctor working in the NHS ☐
b. access to health records ☐
c. [In England, Wales or Northern Ireland] compulsory admission under the Mental Health Act and/or treatment received thereafter ☐
d. [In Scotland] care or treatment given to those suffering from a mental disorder ☐

If any ticks here go to Q1.7

e. none of these ☐ → Q1.8

1.7 Is there any reason to believe that the enquirer has already referred this matter to the appropriate complaints' handling body and exhausted that body's procedures before writing to the GMC?

Yes ☐ → Q1.8
No ☐ → Q1.9

1.8 *[NOTE: before the caseworker proceeds to seek consent etc. from the enquirer, where necessary, under the following section, he or she should consider whether this case should be referred to screeners under the initial screening procedures for treatment-related cases using SDF section B]*

Is the enquirer willing to:

a. Identify the doctor(s)?
Yes ☐ → Q1.8b
No ☐ → Q1.9a

b. Allow the GMC to disclose this to the doctor(s)?
Yes ☐ → Q1.8c
No ☐ → Q1.9a

c. Make a sworn statement?
Yes ☐ → Section 2
No ☐ → Q1.9a

If any answers are unknown, request further information from the enquirer before completing this section and progressing to Section 2. This can include requesting information for medical screening.

1.9a Is there any other reason why the enquiry should be seen by the Medical Screener?

Yes ☐ → Q1.9b
No ☐ → Q1.10

....

....

....

1.10 Declaration and certificate to close enquiry

Completed by Caseworker

I certify that I have processed this case in accordance with the instructions approved by the Screeners and that the information on this form matches that on the FPD system.

Signature .... Date ....

Name ....

Completed by Casework Manager

I have examined this case. I certify that in my opinion there are no grounds to seek information about the doctor's fitness to practise from a source other than the complainant. I am satisfied that this case may be closed.

Signature .... Date ....

Name ....

Fitness to Practise

Add Doctor to Case 2002/1608

Doctor Complainant Help

Reg. Number

Surname: Unknown

Forenames

Salutation | Sex | Full Regn. Date | Date of Birth | Ethnic origin | Country of Qualification

Registered Qualifications

Erasure Code

Address

Post Code

Specialty: Unknown

Sub specialty: Unknown

More

Field of Practice: Unknown

Grade

Identity Confirmed

Alarm Code

Set

Last Updated

Date

By

Add to Case

Cancel

Exit

Start | Inbox - Mic... | Microsoft W... | Fitness t... | IRS - [SKEL... | Insideinfo... | Untitled - M... | Desktop » | 10:48

Programs

Regards.

Code A

Investigation Coordinator

0207 448 9420

WITH COMPLIMENTS

Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG

Telephone: 020 7448 9200
Fax: 020 7448 9222
Text phone: 020 7448 9292
www.chi.nhs.uk
Report order line: 0870 600 5522

MEDIA SERVICES

FACSIMILE

TO: KAM	FROM: Susan Rolling
Fax: 0207 9153685	Direct Tel: Code A
Tel:	Date: 04 07 02
Re: Gosport War Memorial Hospital	Pages: 2

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY

If you have queries, please ring my colleague ~~[illegible]~~ RICHARD HORROBIN on ~~[illegible]~~ Code A

Hampshire Constabulary Media Services
Police Headquarters, Romsey Road,
Winchester SO22 5DB
T: 01962 871619 F: 01962 871194
mediaservices@hampshire.police.uk

www.hampshire.police.uk

MEDIA SERVICES

NEWS RELEASE

GOSPORT WAR MEMORIAL HOSPITAL – POLICE WELCOME REPORT

Hampshire Constabulary welcomes the Commission for Health Improvement's report, which has concentrated on the policies and procedures at Gosport War Memorial Hospital.

The police investigation was carried out to identify and focus on any potential criminal activity. The Crown Prosecution Service has consistently advised that there are no grounds for prosecution.

The Commission's report hopefully reassures concerned relatives that this matter has been examined, and key recommendations made.

The constabulary continues to actively review this complex investigation in the context of complaints against police made by relatives, and will act accordingly on any findings from that process.

This case concentrates on issues of major significance, and has potential ramifications for many agencies.

It must be seen against the backdrop of care for the elderly being provided with transparency and accountability to best health practice and the law.

RH030702

Hampshire Constabulary Media Services
Police Headquarters, Romsey Road,
Winchester SO22 5DB
T: 01962 871619 F: 01962 871194
mediaservices@hampshire.police.uk

CRIMESTOPPERS 0800 555 111

Our Reference: HM/FPD/2002/1608

12 July 2002

GENERAL
MEDICAL
COUNCIL
Protecting patients, guiding doctors

Commission for Health Improvement
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Dear Sir/Madam

Gosport War Memorial Hospital

Thank you for your letter, the contents have been noted. Your enquiry is being considered and we shall write again as soon as possible.

Your case has been allocated the following reference number Code A It would be very helpful if you could quote this reference number whenever you write or speak to us.

Yours sincerely

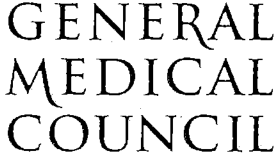
Code A

Stephen Kelly
Fitness to Practise
Code A

Your reference:

Our reference: 2002/1608

21 August 2002



Protecting patients, guiding doctors

First Class Post

Dr R I Reid
Medical Director
Queen Alexandra Hospital
Southwick Hill Road
Cosham
Portsmouth PO6 3LY

Dear Dr Reid

Portsmouth Healthcare NHS Trust (CHI Report)

I write further to our previous correspondence and telephone conversations concerning the Gosport War Memorial Hospital.

This letter concerns the recently published report by the Commission for Health Improvement (CHI) into the Gosport War Memorial Hospital. I appreciate that Portsmouth Healthcare NHS Trust, as was, no longer exists and has been replaced by a number of smaller Trusts. I apologise therefore if my letter is incorrectly directed to you and should be grateful if you would forward it to the appropriate person/office.

We have now reviewed the CHI report and noted it's findings and recommendations. At paragraph 2.8 of the report it is mentioned that the Trust received 10 complaints concerning patients treated on Daedalus, Dryad and Sultan Wards at Gosport War Memorial Hospital since 1998.

You are aware that in the wake of the investigation by Hampshire Constabulary the GMC was contacted directly by a number of relatives of patients who died at Gosport. These are listed below:

Complainant	Deceased relative
Mr C R S Farthing	Arthur Cunningham
Mrs G McKenzie	Gladys Richards
Mr I Wilson	Robert Wilson
Mr B Page	Eva Page
Mrs M Jackson	Alice Wilkie
Mr M Bulbeck	Dulcie Middleton

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Mrs A Reeves	Elsie Devine
Mrs R Carby	Stanley Carby
Mr M Wilson	Edna Purnell

I should imagine that our list relates fairly closely to the 10 complaints received by the Trust. However, I should be grateful if you would provide me with brief details of any further complaints received by the Trust not listed above.

Thank you in advance for your assistance.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate

Code A

East Hampshire NHS
Primary Care Trust

Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
Portsmouth
Hants
PO6 3LY

Tel: 023 9228 6000
Fax: 023 9220 0381
Direct Line: Code A

Mr M Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE

Ref: RIR/cmp

29 August 2002

Dear Mr Hudspith

Thank you for your letter of 21st August 2002.

I enclose a list of the names associated with the ten complaints which were referred to in the CHI report.

A very brief resume of the issues raised in respect of the complaints about which you have no knowledge is included. If you would like further detail of these I would suggest that you contact Fiona Cameron, Operational Director, Fareham & Gosport Primary Care Trust, Unit 180 Fareham Reach, 166 Fareham Road, Gosport, Hants, PO13 0FH, tel: Code A.

In respect of Mrs Batson's complaint, Fiona Cameron recently spoke to Mrs Batson on the telephone and she indicated that she was happy with the way her complaint had been resolved.

Fiona Cameron also reports that the Windsor family seemed happy after receiving an apology from Dr Knapman, the G.P. involved.

With the exception of the Dungworth re Madgewick complaint, Fiona Cameron states that all complaints, to the best of her knowledge, have now been resolved.

In respect of the complaints to the GMC, the Trust has never received any complaint from Mr I Wilson, Mr B Page, Mrs M Jackson, Mrs R Carby. The Trust has only very recently received a complaint from Mrs Bulbeck (but this was not one of the ten referred to in the CHI report).

I shall be on holiday from 2nd – 22nd September. Could I suggest if you have any queries in the meantime or any information about Dr Barton, that you contact Ian Piper the Chief Executive of Fareham & Gosport Primary Care Trust at the above address (or alternatively Fiona Cameron, the Operational Director).

House, Hulbert Road, Waterlooville, Hants, PO7 7GP, tel: Code A East Hampshire Primary Care Trust is now Dr Lord's employer and I am effectively the Medical Director (for secondary care services) for East Hampshire PCT and Fareham & Gosport PCT.

Yours sincerely

Code A

Dr Ian Reid
Medical Director

cc: Ian Piper
Fiona Cameron
Tony Horne

Enc

Farthing re Cunningham	Oct. '98	Dryad	On GMC list.
Wilson re Purnell	Nov. '98	Dryad	On GMC list.
Lack/McKenzie re Richards	Aug. '98	Daedalus	On GMC list.
Reeves re Devine	Jan. '00	Dryad	On GMC list.
Riply re Ripley	Jul. '00	Sultan	Communication with relatives/management of pain.
Batson re Gilbertson	Jun. '00	Dryad	Management of pressure areas/pain relief/use of morphine/lack of info. and involvement in care/nutrition and fluid intake.
Paddon-Hall re Hall	May '01	Sultan	Nurses dress code and attitudes of staff.
Slaymaker re Saffin	Dec. '99	Daedalus	Management of leg ulcers.
Windsor re Windsor	Aug. '00	Sultan	Delay in transfer/management of food and fluids and communication with family. Family met with Dr Knapman and Fiona Cameron.
Dungworth re Madgewick	Dec.'01	Dolphin Day Hospital	Management of venflon site. IRP request turned down, for external review of medical notes by Dr Graham Dewhurst. Family have already met Dr Mike Bacon and Fiona Cameron.

Your reference: RIR/cmp

Our reference: 2002/1608

3 September 2002

Fiona Cameron (Operational Director)
Fareham and Gosport Primary Care Trust
Unit 180 Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

FILE COPY

Dear Ms Cameron

Gosport War Memorial Hospital

I am to you at the suggestion of Dr Ian Reid who I understand is currently on annual leave. I enclose copies of my letter of 21 August 2002 to Dr Reid and his subsequent response of 29 August 2002 for your information. The contents should be self explanatory.

Of the 10 complaints listed in Dr Reid's resume only the complaint of Mrs Batson would appear to raise issues which may warrant further consideration by the GMC. In order to assist us in deciding whether or not this is the case, I should be grateful if your would provide me with full details of this particular complaint, including the names of those doctors complained about.

Thank you in advance for your assistance.

Yours sincerely

Michael Hudspith
Fitness to Practise Directorate

Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Your ref: RIR/cmp

3 September 2002

Dr Ian Reid
Department of Medicine for Elderly People
Queen Alexandra Hospital
Cosham
Portsmouth
Hants
PO6 3LY

Dear Dr Reid

Thank you for your letter dated 29 August 2002, the content of which is receiving attention and we shall write again in due course.

Yours sincerely

Code A

Thomas Wood
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Tel: 01329 233447
Fax: 01329 234984

Rec'd 1/10/02

Mr Michael Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE

FC/MT

30 September 2002

Dear Mr Hudspith

Re: Gosport War Memorial Hospital

Thank you for your letter of 3 September. In response I am enclosing Mrs Batson's original complaint and Portsmouth HealthCare Trust's final response to the complaint. Dr Ian Reid was the consultant in charge of this case and Dr Jane Barton the clinical assistant working with him.

I hope this information is helpful. However, if there is anything further you require, please do not hesitate to contact me.

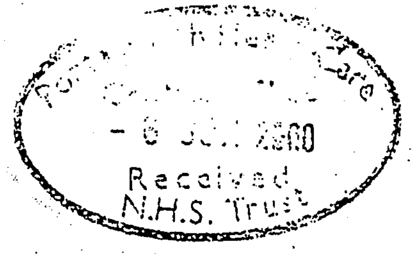
Yours sincerely

Code A

Fiona Cameron
Operational Director

Enc.

app(1)



40 Fareham Park Road.
Fareham.
PO15 6LE.

2 June 2000

Dear Mr Millett,

Would you please take this document as a formal complaint about the treatment that was metered out to my mother Mrs Velma Gilbertson whilst she was a patient at the Gosport War Memorial Hospital last November/December? My complaint is directed towards Dryad Ward and no other. The week she spent in Mulberry Ward was splendid, the care here was second to none and I am most grateful for their excellent efforts on Mum's behalf. Every day Mum was washed, dressed and taken into the main ward where she enjoyed the inter-activity and banter enjoyed by most members of a ward when that patient is so obviously on the road to recovery after a very long journey. She had two, much longed for baths and had her hair washed and set. The contrast therefore was so much greater when she was transferred to the floor below.

For ease and clarity I have taken the liberty of merely listing the problems, which we as a family encountered, my brother Michael is also in agreement to the sending of this letter: -

1. In opposition to advice given by every other medical person we had encountered, (Mum having been in Queen Alexander Hospital since the beginning of September), it was decided by Dryad Ward to confine Mum to bed the reason stated was that this was the best way to begin the healing process of the pressure sores that she had developed. In fairness a proper mattress was provided but that was all. Why does this ward offer different pressure sore advice to every other, outside, (including the District Nurses) medical practitioner who without exception says confining the patient to bed is the last thing a pressure sore needs to heal it?

2. Pain Relief. Mother was indeed in a great deal of pain and discomfort with both her back and her legs; she has suffered from Osteo-Arthritis for many years. At the first of many meetings with the medical team, it was mentioned that Oral Morphine might be the best form of pain control. In truth my initial horror at the suggestion of the administration of any form of this strong medication was only assuaged by Dr Barton who advised me that Morphine was not only an excellent pain reliever but; enhanced healing, stimulated the appetite and was a most efficient mood enhancer. Whilst subsequent medical folk have agreed with the pain killing effect, they have without exception shown great surprise at any mention of this drug being either a healer or an appetite stimulant. Having regard to the suggestion of their being any mood enhancing, they have suggested the opposite in that it is a drug that will by its very nature, make the patient very drowsy. Would you please try to explain this difference in advice?

3. As stated in 1 above, Mum's pain was great and following another meeting this time with Dr Reid, my brother and the ever present, note taking, Sister Hamlin, it was decided to proceed with the prescribing of Oral-Morphine. The anti-inflammatory drugs Mum had been having were withdrawn. Day after day, night after night found Mum sitting bolt upright in

remember being reduced to tears at that stage as I had arranged Mum's transfer to Gosport to improve her health not to watch her die.

I believe that Dryad Ward practices a regime that is totally out of date and needs serious modernisation. To exclude a family that has so obviously put lots of time and effort into the well being of their beloved parent seems somewhat arrogant to say the least. The frustration that we all felt during this most stressful time cannot begin to be explained and it is with little surprise that tempers were frayed on more than one occasion. To be told repeatedly that, (even about the simplest of tasks)"We don't do things like that on this ward", can only lead to conflict and that was what we experienced every day of Mum's hospitalisation.

I have been in contact with C.A.B and Age Concern who have both urged me to write this letter to you. I have written this within the timescale laid down and I write in the hope that drawing attention to our problems even at this late stage may help other families who feel that the system has let them down. I have not as has been suggested to me sent a copy of this to the local M.P. I would wish to hear from your office in the first instance.

I am, yours most sincerely,

Code A

Daphne Batson.

bed, to say that she looked very uncomfortable would be an under statement to top all others. Obviously the staff was reluctant to move Mum, because of her suffering. Why then did it take a week and a day for the Morphine to arrive onto the ward and the administration begin?

4. My brother and I have always been encouraged by all other Hospital Wards to offer as much mental help by way of visits and support, and practical help, by way of assisting with dressings, eating and washing. Imagine then our total shock when we encountered the regime practiced by Dryad Ward. As next of kin we did not expect to be asked to leave the room every time a dressing was changed or Mum was washed. Arguably the Ward may say that it was not a mans place to be there at these times but my brother and I have personally and intimately cared for Mum over a long period of time and especially since the loss of Dad over three years ago. The Ward was aware of this. My brother and I were removed from the room at all times and the last straw was when, following the most stressful and acrimonious period, Dr Reid came to Mum's room on the evening we were scheduled for yet another meeting to discuss our feelings of frustration and helplessness regarding Mum's treatment, my brother and I were asked to leave the room and the door was actually closed with us left outside feeling humiliated and staggered at the total lack common courtesy shown by this senior practitioner. He was accompanied as always by another member of staff, Sister Hamblin on this occasion , because never in the weeks Mum was in this ward did staff ever attend alone, always in twos, which gave the impression, rightly or wrongly that there was a need for a chaperone or another member of staff as witness at all times. I can only speak for myself on this occasion when I say that I have never before encountered such total insensitivity towards and disregard for, feelings and consider this action to be the height of rudeness and bad manners and especially so, coming from professional people such as these. One would never have thought we were Mum's next of kin.
Why were we so totally excluded from any input regarding our Mother's well being it was as though our love and regard for Mum was not even part of the equation? Surely this Dickens - ion approach to hospitalisation is shocking in the light of todays political correctness.

5. I was sitting with Mum one evening when I asked one of the senior nurses who was at that time attending to the drugs trolley, what medication mum was on and yet again on this ward I felt thoroughly rejected when I was given the answer that this information could not be given, as it would contravene the patient's charter. The drugs record file was quite literally slammed shut. I asked what Mum's blood sugars were, same answer, I asked what levels of insulin Mum was on and yet again this information was not forthcoming. I had taken in for Mum some Kamillosan (a herbal lip salve) for her dry lips and some Bonjella to help the discomfiture of a gum ulcer. When I looked for these two items in Mum's drawer, they had been taken away; I was told by the same senior nurse that all medication was to be kept in the drugs cupboard. The items were returned on request and I was told that they were not to be used and that I should take them home.

Why this totally unsympathetic and dictatorial approach? We were encouraged by all other local Hospitals as I have said before, to have total input and interest in our Mother's treatment and improvement. Again why the total reverse system at Gosport?

6. Having regard now to Mum's food and liquid intake. Mum is a diabetic and has been at great efforts over these past few years to ensure that blood sugar levels were kept to within an acceptable level this you will agree is done by monitoring the food intake level. We are therefore quite familiar with what is and is not correct. There were no food or drink charts

kept despite our advising the ward that Mother's appetite was poor. In an effort to tempt Mum to eat more I took in diabetic milk puddings, low sugar drinks, various fruits and was told that under no circumstances was I to take in any "titbits", their word not mine. I asked that a Dietician could be called to advise us, told her all the things that I had been bringing in and asked why was it now the wrong thing to give diabetics to eat. Of course she was totally shocked at the suggestion the these foods were not appropriate and gave me another copy of the booklet to leave on the ward, a copy of which we have at home and have always worked too. Dr Ravenjanni had obviously I suggest assumed that it was these foods that had caused the blood sugars to rise, if that was the case, for that must have been the reason to stop home prepared food. I brought in other savoury diabetic foods because the hospital food did not look appetising, though I realise that mass catering is difficult. Because as previously stated as a family we were not made aware of Mum's progress I can draw the conclusion that, as Mum was catheterised a U.T.I may have caused the blood sugar levels to rise. We were never given a reason for the food from home restriction!

7. Whilst I am touching on the subject of the catheter, I will mention the two occasions when I noticed the very dark colour of the urine therein. I twice drew this to the attention of the nurse and the comment was made that, here I quote that nurse "Well she's not drinking very much" my response was to ask why the staff were not actively encouraging Mum to drink more. A shrug of the shoulders was the reply I received.
Why was the liquid intake not monitored to avoid possible kidney problems? Q.A had monitored both food and drink throughput continually.

To conclude this very lengthy and I most truly hope, not too rambling letter of complaint I must add that the few weeks that Mum was in Dryad Ward saw her total decline. Having watched Queen Alexander pull out all the stops to provide everything that Mum could need be it daily physiotherapy, lots of chat and encouragement from all the staff (even though this was a very busy surgical ward, there was always a moment for Mum) they re- kindled the spark of hope in Mum, we had to watch, through the total lack of both mental a physical stimulation, the extinguishing once again, of that spark. Apart from being washed and nightdress changed at least three times a day, (I know this is a fact because I took them home to wash each day) and the administration of the medication, the social input and effort on Mum's behalf seemed minimal. When my brother first met Dr Reid at the beginning of this awful period in all our lives, Dr Reid expressed grave doubts as to his ability to re-habilitate Mum and with that idea in mind I honestly believe that no effort was made to even try.

On the 21st December last year and with the help of Dr Reid, I had Mum brought home to live with us. She remains a poorly lady and indeed progress has been slow but with the help of Fareham District Nurses who attend every other day, a wonderful, supportive and understanding G.P and the total family support she has always enjoyed we look forward to even better days to come.

I believe that both Dr Barton and Dr Reid assumed that Mum had cancer and with only scant evidence from one out of three biopsy tests assumed that Mum was terminally ill. They to my knowledge made no attempt at further diagnostic tests and at the initial meeting with me and in the presence of the note taking Sister Hamlin, Dr Barton suggested that, in her words, ". We had had Mum for a further five or six years following a mastectomy what more did we want". To say that I was shocked would be another under statement; I seem to

remember being reduced to tears at that stage as I had arranged Mum's transfer to Gosport to improve her health not to watch her die.

I believe that Dryad Ward practices a regime that is totally out of date and needs serious modernisation. To exclude a family that has so obviously put lots of time and effort into the well being of their beloved parent seems somewhat arrogant to say the least. The frustration that we all felt during this most stressful time cannot begin to be explained and it is with little surprise that tempers were frayed on more than one occasion. To be told repeatedly that, (even about the simplest of tasks)"We don't do things like that on this ward", can only lead to conflict and that was what we experienced every day of Mum's hospitalisation.

I have been in contact with C.A.B and Age Concern who have both urged me to write this letter to you. I have written this within the timescale laid down and I write in the hope that drawing attention to our problems even at this late stage may help other families who feel that the system has let them down. I have not as has been suggested to me sent a copy of this to the local M.P. I would wish to hear from your office in the first instance.

I am, yours most sincerely,

Code A

Daphne Batson.

Mrs. D. Batson,
Code A

MM/LH/YJM

08 June 2000

5478

Dear Mrs. Batson,

Thank you for writing to me. I was sorry to hear of your concerns about the care provided for your mother, Mrs. Velma Gilbertson, on Dryad Ward. It is very helpful that your concerns are listed so clearly.

We will be conducting an investigation and I will write to you in more detail on its completion. We would usually aim to respond in full to complaints within four weeks, but some investigations take longer. I am aware that a number of key members of staff are on holiday over the next few weeks so it is likely to take more than a month in this case. Our investigating officer, Mrs. Sue Frogley, will contact you soon and we will keep you informed of progress.

The enclosed leaflet explains how the NHS complaints procedure works, including future options open to you.

Yours sincerely,

Max Millett
Chief Executive

Copy to: Mrs. S. Frogley

Mrs. D. Batson,
Code A

MM/LH/YJM

22 August 2000

4378

Dear Mrs. Batson,

Further to my earlier letters I am now able to respond in detail to your complaint about the care provided for your mother, Mrs. Velma Gilbertson, on Dryad ward. We are sorry that it has taken so long to conclude our investigation - thank you for your patience. As you know, our investigating officer, Mrs. Sue Frogley, spoke with those concerned with your complaint, and reviewed medical and nursing records. Following this Mrs. Lesley Humphrey (Quality Manager) and Mrs. Fiona Cameron (General Manager for Gosport and Fareham) reviewed the investigation report, drawing conclusions and making recommendations.

Our investigation highlights the differing expectations of you and your family from the clinical staff. It also very powerfully highlights a breakdown in the relationship and trust between yourselves and the clinical team. I am very sorry for the distress caused by this and I will return later to this issue.

First, I would like to respond to your specific questions in the order that they were posed.

1. Why did Dryad ward offer different pressure sore advice to other areas?

   Mrs. Gilbertson had developed two extensive sacral sores prior to her admission to Dryad ward. A pressure sore assessment completed on the day of admission registered that she was at high risk. A score of 20 or over is considered very high risk and Mrs. Gilbertson scored 27. The best treatment for, and indeed prevention of, pressure sores is to relieve the pressure. We cannot comment on what you have been told by others, however bed rest with a pressure relieving mattress was the appropriate care at this stage - as confirmed by our wound care guidelines (a copy of two of the guide appendices is enclosed).

2. Dr. Barton's advice that morphine enhances healing, stimulates the appetite and is an efficient mood enhancer

   We have checked with our pharmacy advisory service; morphine can cause a state of euphoria and thus enhance a person's mood. There is, however, no identified link between morphine and wound healing or stimulation of appetite. We are sorry that you were given the impression that morphine had these properties.

/continued - page 2

It would be fair to say that relieving someone's pain and enhancing their mood might improve their general feeling of well-being, with a positive effect on their appetite and healing, etc. Conversely, however, morphine can cause nausea and vomiting in some people, and indeed drowsiness. I am sorry that you were left with a false impression of the potential effects of morphine and for the distress this has subsequently caused you.

3. <u>Why did it take a week and a day for the morphine to arrive and administration begin</u>?

It is very clear that pain was a major problem for your mother, and that managing her pain proved to be very difficult, for a number of reasons. As you state in your letter, you were originally horrified at the thought of morphine being used, as was your brother, Mr. Gilbertson. The staff were acutely aware of this and did not want to cause you any upset.

On 8th December, 1999 Dr. Reid saw your mother. He suggested to her that her pain killing medication (analgesics) could be changed (i.e. that morphine could be used) but she was reluctant for this to happen and requested that she stayed on her current medication.

That same day Dr. Reid saw your brother, Mr. Gilbertson. They agreed that it was essential to get your mother's pain under control if she were to get back on her feet. They also agreed that if other analgesics proved to be inadequate we would try to persuade your mother to have morphine.

Your mother's regular pain killing medication at this time consisted of: Tramadol (which is in the same group of medications - opiates - as morphine, but has fewer of the opiate side effects); paracetamol; and ibuprofen (a non-steroidal anti-inflammatory medication). The ibuprofen was stopped on 10th December because of concern that it might be affecting the functioning of your mother's kidneys. When the ibuprofen was stopped a TENS (Trans Electric Nerve Stimulation) machine was introduced, initially with good effect. This machine works by interrupting the pain signals to the brain.

Despite all these efforts however Mrs. Gilbertson remained in pain, particularly on moving. Oral morphine was commenced on 14th December, 1999, six days after Dr. Reid's conversation with Mr. Gilbertson.

From our investigation it seems there was no delay in the morphine arriving or being given; in fact, morphine is routinely kept on the ward. The staff were of the impression that they were following the wishes of Mrs. Gilbertson, and your brother and yourself, by continuing with other analgesics before resorting to morphine.

I understand that morphine made little significant difference to Mrs. Gilbertson's pain. By the 16th December, 1999 Mrs. Gilbertson's condition had begun to deteriorate and it was recognised that the morphine might be contributing to this. At your request, the administration of morphine was stopped, and only subsequently given with your explicit agreement, or on request from your mother.

The whole issue of pain and pain relief seems to have created a great deal of tension between yourselves and the staff. Sometimes pain is difficult to control, and although distressed by her pain it seems that Mrs. Gilbertson was reluctant to accept stronger pain killers. I am very sorry that we were unable to satisfactorily control your mother's pain, and for the distress this caused her and yourselves. On reflection, it seems possible that the tension between you and your family and the clinical staff may have clouded the issue of what would clinically have been in your mother's best interests.

4. Why were you excluded from any input to your mother's well-being?

I think perhaps there are two elements to this question: your influence on and your involvement in Mrs. Gilbertson's care. From our records it is clear that you and your brother had many meetings with the clinical staff, sometimes more than one a day, to discuss your mother's care. The staff felt that they did their best to accommodate your wishes, allowing you to influence care, whilst being mindful of what they felt was clinically in Mrs. Gilbertson's best interests.

With regard to your involvement in your mother's care, and you being asked to leave the room whilst care was provided, it seems that the staff took an unfortunately rigid line. So long as Mrs. Gilbertson agreed, there was no reason why you should not have helped, or indeed provided, some care. (I understand that you did assist with washing.) There is also no reason why you should have been asked to leave the room whilst dressings were changed. I would like to apologise for the rigidity of the nursing approach, and for the distress this caused you.

Dr. Reid remembers the visit you describe. He asked you to leave so that he could talk confidentially to Mrs. Gilbertson about her wishes and how she was feeling. The patient's wishes are always paramount and they have a right to confidentiality which the doctor must respect. Relatives are regularly asked to leave the room so that the doctor can talk privately to the patient. Dr. Reid meant no disrespect to you, nor was he deliberately trying to exclude you. He is sorry that you felt insulted, and he denies showing any discourtesy.

You mention staff always attending in twos, giving the impression that a chaperone or witness was needed. In fact, the staff felt this to be the case. The nature of the relationship between you all was such that staff felt intimidated and, at times, threatened. This was an unfortunate situation for everyone and I will comment more in my conclusion. It would also, however, be fair to say that as many of your questions spanned both medical and nursing issues, it was an advantage to have both a doctor and a nurse present.

5. Why was there an unsympathetic approach to simple medications and to information about blood sugar medication?

There is no valid reason, other than established ward routine, as to why the Kamillosan and Bonjella that you brought into the ward were not left in your mother's locker. These are simple medications which would have caused no harm so long as the package instructions were followed.

/continued - page 4

With regard to giving you information about blood sugar and insulin, the Patient's Charter states "if you agree, you can expect your relatives and friends to be kept up to date with the progress of your treatment", with the aim of preserving the patient's wishes. In your mother's case, given the existing level of your involvement in her care, the response you received to your questions was very unhelpful. If the staff had any doubts about whether your mother wished such information to be shared with you, they should have asked her.

I would like to apologise for this unfriendly approach and rigid routine, and the distress it caused.

6. Restriction on food from home

When Mrs. Gilbertson was admitted to Dryad ward her blood sugars were unstable, they were high. Her blood results and insulin needs were carefully monitored and her diet was strictly controlled. Initially this was best managed through keeping to hospital food, as her food intake needed to be carefully controlled and monitored. To eat food brought from home, in addition to the food provided in hospital, would have caused her blood sugars to rise.

That being said, however, once the situation settled there was no reason why agreement could not have been reached about what foods you would bring in to replace some of the hospital food. The dietitian recorded in the medical notes that she met you on 7th December, 1999 and discussed what foods it would be appropriate for you to bring in. It would, of course, have been important for you to keep this list, and to agree with the ward staff what hospital meals you would be replacing. I am very sorry that this situation was not amicably resolved.

7. Why was liquid intake not monitored to avoid possible kidney problems?

At interview the nursing staff have confirmed that Mrs. Gilbertson was regularly encouraged to drink and her fluids monitored; her care plan for catheter care regularly records that her catheter was draining well. There is, however, no record in the nursing notes of volume of fluid taken or passed. We would expect that specific volumes be recorded if monitoring of intake and output is to be effective. We would not, however, consider it necessary to monitor the fluid balance of all patients; we would only measure when there was a potential or actual problem. I can only apologise that Mrs. Gilbertson's fluid intake and output was not recorded more accurately.

I would now like to turn to the more general comments made at the end of your letter before drawing some overall conclusions.

You felt that Dr. Reid and the rest of the team made no effort to rehabilitate your mother, and that an assumption was made that she was terminally ill with cancer. With regard to the latter, Dr. Reid has stressed that he always had an open mind because there was no evidence of recurrent cancer, and that no assumption was made about terminal cancer. Towards the end of her stay on Dryad ward he was, however, of the opinion that Mrs. Gilbertson's condition was deteriorating, that she had little strength or reserves left, and that it was quite likely that she would die. I understand that he explained his concerns to you on 16th December, 1999.

With regard to rehabilitation, Mrs. Gilbertson had spent some three months in Queen Alexandra Hospital before moving to Dryad ward. From the notes it seems that for quite some time before she left Queen Alexandra Hospital there was concern that she was unlikely to regain much mobility. You may remember Dr. Logan visiting to give an opinion on whether she might be suitable for his rehabilitation ward. After assessing your mother's needs he concluded that there was little likelihood of any success from formal rehabilitation. He felt she was reaching the end of her life, that she had huge nursing needs, and would be likely to need long-term nursing care, possibly in a nursing home. Before she was admitted to Dryad ward Mrs. Gilbertson could not stand and bending her knees caused extreme pain, in addition to her surgical wounds and extensive pressure sores. The physiotherapist at Queen Alexandra Hospital recorded that trying to mobilise and sitting out in a chair aggravated your mother's pain, while resting alleviated the pain.

Mrs. Gilbertson's pain severely limited any rehabilitation. Dr. Reid explained that if her pain could be brought under control it might be possible to try to get her back on her feet. It was not that no efforts were made, but that rehabilitation in these circumstances was not possible.

With regard to your comments that "Dryad ward practice a regime that is totally out of date", we would agree from our investigation that there are some areas of ward philosophy and practice which need updating. The service manager will be working closely with the ward manager to review and revise how some aspects of care are managed.

So, our conclusions. Understandably you, your mother and your brother had a desire for Mrs. Gilbertson to be returned to the state of health she had enjoyed before she was admitted to Queen Alexandra Hospital. The collective opinion of a number of clinicians (not just from Dryad ward) was that rehabilitation was unlikely to be successful and probably impossible. The doctors and nurses on Dryad ward spent many hours discussing this with you. Given all the circumstances, the care provided on Dryad ward was appropriate to Mrs. Gilbertson's clinical needs, and indeed to her personal capabilities, at the time.

This fundamental (and seemingly unresolvable) difference in opinion and expectation between yourselves and the clinical team led to a breakdown in the relationships and trust between you all. You refer in your letter to frustration and frayed tempers on more than one occasion. I understand that the staff too felt frustrated and also felt that this conflict affected their ability to provide what in their professional opinion would be the most appropriate care for your mother. You obviously care deeply for your mother and wish the best for her. Equally the staff had a duty of care towards her. Balancing her assessed clinical needs against your wishes for her care seems to have turned into a power struggle.

Unfortunately there seems to have been no winners, only losers, in this struggle. We have to conclude that everyone concerned had some responsibility for this situation developing as it did. The service manager will be working with the ward team to explore the ways of building effective partnerships with relatives, and in handling conflict. Dr. Barton no longer works for the Trust so she will not be included in this work.

We have thought long and hard about the issues raised in your letter, which I hope is indicated in this response. I also hope that this helps to clarify the different perspectives about what happened and why. Please let me know within one month if there is any further action you would like me to take.

/continued - page 6

I realise that you will not be completely happy with all of this reply, but do hope that you will accept our apologies for the shortfalls in nursing care.

You mentioned to Mrs. Frogley, investigating officer, that you would like to see a copy of the notes made by the nursing staff during meetings. The only records retained are the notes made on the nursing contact sheet which quite extensively detail your conversations. Mrs. Frogley has confirmed that Mrs. Gilbertson has agreed to you having access to her records in this way. Enclosed is a full copy of these contact notes.

Mrs. Frogley was very impressed with the care you provide for your mother at home, and I hope Mrs. Gilbertson's remains comfortable at home.

Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Dr. I. Reid
Mrs. F Cameron

In reply please quote Mhu/FPD/2000/2047

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

4 October 2002

Ms Fiona Cameron
Operational Director
Fareham and Gosport
NHS Primary Care Trust
Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Dear Ms Cameron

Re: Gosport War Memorial Hospital

Thank you for your letter and enclosures of 30 September 2002, the contents of which have been noted.

Your correspondence has been passed to Mr Michael Hudspith for his attention.

Yours sincerely

Code A

Desrine Emmanuel
Fitness to Practise Directorate

Code A

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

Michael Hudspith (7915 3617)

From:	Michael Keegan (7915 7437)
Sent:	04 Oct 2002 15:48
To:	Michael Hudspith (7915 3617)
Subject:	Dr Barton

Michael,

Thanks for your memo regarding additional Barton-related information.

I am about to write to FFW and copy your memo to them. At a case conference yesterday it was suggested that additional cases (such as those relating to Mr Carby and Mrs Gilbertson) may be added under Rule 11, as you inquire. FFW will, no doubt, wish to see the additional papers you have.

Perhaps you could discuss the matter when you get a chance?

Michael Keegan
Conduct Case Presentation Section

Code A

GMC100829-0426

Investigation

Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital

JULY 2002

GMC100829-0427

Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

JULY 2002

GMC100829-0428

Published by TSO (The Stationery Office) and available from:

Online
www.tso.co.uk/bookshop

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/General enquiries: 0870 600 5522
Fax orders: 0870 600 5533
E-mail: book.orders@tso.co.uk
Textphone 0870 240 3701

TSO Shops
123 Kingsway, London, WC2B 6PQ
020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
0121 236 9696 Fax 0121 236 9699
9-21 Princess Street, Manchester M60 8AS
0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
18-19 High Street, Cardiff CF10 1PT
029 2039 5548 Fax 029 2038 4347
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

TSO Accredited Agents
(see Yellow Pages)

and through good booksellers

© Commission for Health Improvement 2002

Items may be reproduced free of charge in any format or medium provided that they are not for commercial resale. This consent is subject to the material being reproduced accurately and provided that it is not used in a derogatory manner or misleading context.
The material should be acknowledged as © 2002 Commission for Health Improvement and the title of the document specified.

Applications for reproduction should be made in writing to
Chief Executive, Commission for Health Improvement, 103-105 Bunhill Row, London EC1Y 8TG.

A CIP catalogue record for this book is available from the British Library.
A Library of Congress CIP catalogue record has been applied for.

First published 2002

ISBN 0 11 703023 6

Contents

Acknowledgements v
Executive summary vii

1. Terms of reference and process of investigation 1

Terms of reference 1
CHI's investigation team 2
The investigation process 2

2. Background to the investigation 4

Events surrounding the CHI investigation 4
Complaints to the trust 5
Action taken by the health authority 5
Action taken by the NHS South East regional officials 6

3. National and local context 7

National context 7
Trust background 7
Local services for older people 8
Service performance management 9
Inpatient services for older people at the Gosport War Memorial Hospital 1998–2002 9
Terminology 10

4. Arrangements for the prescription, administration, review and recording of medicines 12

Police inquiry and expert witness reports 12
Medicine usage 13
Prescription writing policy 17
Administration of medicines 17
Structure of pharmacy 19

5. Quality of care and the patient experience 21

Introduction 21
Patient experience 21
Stakeholder views 21
Outcome of CHI observation work 23

6. Staffing arrangements and responsibility for patient care 27

Responsibility for patient care 27
Clinical assistant role 28
Appraisal and supervision of clinical assistants 29
Sultan ward 29
Out of hours cover provided by GPs 29
Appraisal of hospital medical staff 30
Nursing responsibility 30
Nursing supervision 30
Teamworking 31
Allied health professional structures 31
Workforce and service planning 32
Access to specialist advice 32
Staff welfare 33

7. Lessons learnt from complaints 35

External review of complaints 35
Complaint handling 35
Trust learning regarding prescribing 36
Other trust lessons 37
Monitoring and trend identification 37

8. Clinical governance 39

Introduction 39
Clinical governance structures 39
Risk management 40
Raising concerns 41
Clinical audit 41

Appendices 43

A. Documents received by CHI and/or referred to in the report 43
B. Views from patients and relatives/friends 54
C. Portsmouth Healthcare NHS Trust staff and non executive directors interviewed by CHI 57
D. Meetings or telephone interviews with external agencies with an involvement in elderly care at Gosport War Memorial Hospital 59
E. Medical case note review team: terms of reference and membership 61
F. Report of the Gosport investigation medical notes review group 63
G. An explanation of the dissolution of services in the new primary care trusts 65
H. Patient throughput data 1997/1998 - 2000/2001 66
I. Breakdown of medication in Dryad, Sultan and Daedalus wards Gosport War Memorial Hospital 67
J. Glossary 69

GMC100829-0431

Acknowledgements

CHI wishes to thank the following people for their help and cooperation with the production of this report:

- the patients and relatives who contributed either in person, over the phone or in writing. CHI recognises how difficult some of these contacts were for the relatives of those who have died
- staff interviewed by CHI's investigation team (see appendix C) and those who assisted CHI during the course of the investigation. In particular Fiona Cameron, General Manager, Caroline Harrington, Corporate Governance Advisor, Max Millett, Chief Executive (until 31 March 2002) and Ian Piper, Chief Executive of Fareham and Gosport Primary Care Trust (since 1 April 2002)
- staff and patients who welcomed the CHI team on to the wards during observation work
- Detective Superintendent John James, Hampshire Constabulary
- the agencies listed in appendix D who gave their views and submitted relevant documents to the investigation

GMC100829-0432

Executive summary

CHI has undertaken this investigation as a result of concerns expressed by the police and others around the care and treatment of frail older people provided by Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. This follows police investigations between 1998 and 2001 into the potential unlawful killing of a patient in 1998. As part of their investigations, the police commissioned expert medical opinion, which was made available to CHI, relating to a total of five patient deaths in 1998. In February 2002, the police decided not to proceed with further investigations.

Based on information gathered during their investigations, the police were sufficiently concerned about the care of older people at Gosport War Memorial Hospital to share their concerns with CHI in August 2001. CHI is grateful to the Hampshire Constabulary for sharing information with us which contributed towards the local and national recommendations CHI makes to improve the care of this vulnerable group of NHS patients.

CHI has conducted a detailed review of the systems in place to ensure good quality patient care. CHI does not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual.

Key conclusions

CHI concludes that a number of factors, detailed in the report, contributed to a failure of trust systems to ensure good quality patient care:

- there were insufficient local prescribing guidelines in place governing the prescription of powerful pain relieving and sedative medicines
- the lack of a rigorous, routine review of pharmacy data led to high levels of prescribing on wards caring for older people not being questioned
- the absence of adequate trust wide supervision and appraisal systems meant that poor prescribing practice was not identified
- there was a lack of thorough multidisciplinary total patient assessment to determine care needs on admission

CHI also concludes that the trust now has adequate policies and guidelines in place which are being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Key findings

National and local context (Chapter 3)

- Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team.
- 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.

Arrangements for the prescription, administration, review and recording of medicines (Chapter 4)

- 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.

Quality of care and the patient experience (Chapter 5)

- 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.
- Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

Staffing arrangements and responsibility for patient care (Chapter 6)

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff.

Lessons learnt from complaints (Chapter 7)

- The police investigation, the review of the Health 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.

Clinical governance (Chapter 8)

- The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

Recommendations

It is clear from a number of CHI recommendations to the Fareham and Gosport Primary Care Trust (PCT) and the East Hampshire PCT, that continued close and effective working relationships between both PCTs will be essential in order to implement the recommendations in this report. CHI is aware of the high level of interdependence that already exists between these two organisations and urges that this continues.
CHI is aware that many of these recommendations will be relevant to emerging PCTs and urges all PCTs to take action where appropriate.

Fareham and Gosport/ East Hampshire Primary Care Trust

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

3. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

4. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

5. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

6. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

7. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

8. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

9. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

10. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

11. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

12. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

13. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

14. The Fareham and Gosport PCT and the East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

15. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

16. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangements, clinical governance responsibilities and training needs.

17. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

18. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

19. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

20. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

21. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

22. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

Hampshire and Isle of Wight Strategic Health Authority

23. Hampshire and Isle of Wight Strategic Health Authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

Department of Health

24. The Department of Health should assist in the promotion of an NHS wide understanding of the various terms used to describe levels of care for older people.

25. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

1 | Terms of reference and process of investigation

1.1 During the summer of 2001, concerns were raised with CHI about the use of some medicines, particularly analgesia and levels of sedation, and the culture in which care was provided for older people at the Gosport War Memorial Hospital. These concerns were also about the responsibility for clinical care and transfer arrangements with other hospitals.

1.2 On 22 October 2001, CHI launched an investigation into the management, provision and quality of healthcare for which Portsmouth Healthcare NHS Trust was responsible at the Gosport War Memorial Hospital. CHI's decision was based on evidence of high risk activity and the likelihood that the possible findings of a CHI investigation would result in lessons for the whole of the NHS.

Terms of reference

1.3 The investigation terms of reference were informed by a chronology of events provided by the trust surrounding the death of one patient. Discussions were also held with the trust, the Isle of Wight, Portsmouth and South East Hampshire Health Authority and the NHS south east regional office to ensure maximum learning locally and for the NHS.

1.4 The terms of reference agreed on 9 October 2001 are as follows:

The investigation will look at whether, since 1998, there had 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.

CHI's investigation team

1.5 CHI's investigation team were:

- Alan Carpenter, Chief Executive, Somerset Coast Primary Care Trust
- Anne Grosskurth, CHI Support Investigations Manger
- Dr Tony Luxton, Consultant Geriatrician, Cambridge City Primary Care Trust
- Julie Miller, CHI Lead Investigations Manager
- Maureen Morgan, Independent Consultant and former Community Trust Nurse Director
- Mary Parkinson, lay member (Age Concern)
- Jennifer Wenborn, Independent Occupational Therapist

1.6 The team was supported by:

- Liz Fradd, CHI Director of Nursing, lead CHI director for the investigation
- Nan Newberry, CHI Senior Analyst
- Ian Horrigan, CHI Analyst
- Kellie Rehill, CHI Investigations Coordinator
- a medical notes review group established by CHI to review anonymised medical notes (see appendix E)
- Dr Barry Tennison, CHI Public Health Adviser

The investigation process

1.7 The investigation consisted of five interrelated parts:

- review and analysis of a range of documents specific to the care of older people at the trust, including clinical governance arrangements, expert witness reports forwarded by the police and relevant national documents (see appendix A for a list of documents reviewed)
- analysis of views received from 36 patients, relatives and friends about care received at Gosport War Memorial Hospital. Views were obtained through a range of methods, including meetings, correspondence, telephone calls and a short questionnaire (see appendix B for an analysis of views received)

- a five day visit by CHI's investigation team to Gosport War Memorial Hospital when a total of 59 staff from all groups involved in the care and treatment of older people at the hospital and trust managers were interviewed. CHI also undertook periods of observation on Daedalus, Dryad and Sultan wards (see appendix C for a list of all staff interviewed)
- interviews with relevant agencies and other NHS organisations, including those representing patients and relatives (see appendix D for a list of organisations interviewed)
- an independent review of anonymised clinical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. The term of reference for this piece of work, the membership of the CHI team which undertook the work, and a summary of findings are attached at appendices E and F. CHI shared the summary with the Fareham & Gosport PCT in May 2002

2 | Background to the investigation

Events surrounding the CHI investigation

Police investigations

2.1 A relative of a 91 year old patient who died in August 1998 on Daedalus ward made a complaint to the trust about her care and treatment. The police were contacted in September 1998 with allegations that this patient had been unlawfully killed. A range of issues were identified by the police in support of the allegation and expert advice sought. Following an investigation, documents were referred to the Crown Prosecution Service in November 1998 and again in February 1999. The Crown Prosecution Service responded formally in March 1999 indicating that, in their view, there was insufficient evidence to prosecute any staff for manslaughter or any other offence.

2.2 Following further police investigation, in August 2001, the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any member of staff.

2.3 Local media coverage in March 2001 resulted in 11 other families raising concerns about the circumstances of their relatives' deaths in 1997 and 1998. The police decided to refer four of these deaths for expert opinion to determine whether or not a further, more extensive investigation was appropriate. Two expert reports were received in December 2001 which were made available to CHI. These reports raised very serious clinical concerns regarding prescribing practices in the trust in 1998.

2.4 In February 2002, the police decided that a more intensive police investigation was not an appropriate course of action. In addition to CHI, the police have referred the expert reports to the General Medical Council, the United Kingdom Central Council (after 1 April 2002, the Nursing and Midwifery Council), the trust, the Isle of Wight, Portsmouth and East Hampshire Health Authority and the NHS south east regional office.

2.5 The police made the trust aware of potential issues around diamorphine usage in December 1998, and were sent the expert witness reports in February 2002.

Action taken by professional regulatory bodies

2.6 The General Medical Council is currently reviewing whether any action against any individual doctor is warranted under its fitness to practice procedures.

2.7 The Nursing and Midwifery Council are considering whether there are any issues of professional misconduct in relation to any of the nurses referred to in police documentation.

Complaints to the trust

2.8 There have been 10 complaints to the trust concerning patients treated on Daedalus, Dryad and Sultan wards since 1998. Three complaints between August and December 1998 raised concerns which included pain management, the use of diamorphine and levels of sedation on Daedalus and Dryad wards, including the complaint which triggered the initial police investigation. This complaint was not pursued through the NHS complaints procedure.

Action taken by the health authority

2.9 In the context of this investigation, the Isle of Wight, Portsmouth and East Hampshire Health Authority had two responsibilities. Firstly, as the statutory body responsible for commissioning NHS services for local people in 1998 and, secondly, as the body through which GPs were permitted to practice. Some of the care provided to patients at the Gosport War Memorial Hospital, as in community hospitals throughout the NHS, is delivered by GPs on hospital premises.

2.10 In June 2001, the health authority voluntary local procedure for the identification and support of primary care medical practitioners whose practice is giving cause for concern reviewed the prescribing practice of one local GP. No concerns were found. This was communicated to the trust.

2.11 In July 2001, the chief executive of the health authority asked CHI for advice in obtaining a source of expertise in order to reestablish public confidence in the services for older people in Gosport. This was at the same time as the police contacted CHI.

2.12 Following receipt of the police expert witness reports in February 2002, the health authority sought local changes in relation to the prescription of certain painkillers and sedatives (opiates and benzodiazepines) in general practice.

Action taken by the NHS south east regional office

2.13 For the period of the investigation, the NHS regional offices were responsible for the strategic and performance management of the NHS, including trusts and health authorities. The NHS south east regional office had information available expressing concerns around prescribing levels at the Gosport War Memorial Hospital. Information included a report by the Health Service Ombudsman and serious untoward incident reports forwarded by the trust in April and July 2001 in response to media articles about the death of a patient at the Gosport War Memorial Hospital.
The health authority and NHS south east regional office met to discuss these issues on 6 April 2001.

3 | National and local context

National context

3.1 The standard of NHS care for older people has long caused concern. A number of national reports, including the NHS Plan and the Standing Nursing and Midwifery Committee's 2001 annual report found aspects of care to be deficient. National concerns raised include: an inadequate and demoralised workforce, poor care environments, lack of seamless care within the NHS and ageism. The NHS Plan's section *Dignity, security and independence in old age*, published in July 2000, outlined the government's plans for the care of older people, detailed in the national service framework.

3.2 The national service framework for older people was published in March 2001 and sets standards of care for older people in all care settings. It aims to ensure high quality of care and treatment, regardless of age. Older people are to be treated as individuals with dignity and respect. The framework places special emphasis on the involvement of older patients and their relatives in the care process, including care planning.

3.3 National standards called *Essence of Care*, published by the Department of Health in 2001, provide standards for assessing nursing practice against fundamental aspects of care such as nutrition, preventing pressure sores and privacy and dignity. These are designed to act as an audit tool to ensure good practice and have been widely disseminated across the NHS.

Trust background

3.4 Gosport War Memorial Hospital was part of Portsmouth Healthcare NHS Trust between April 1994 and April 2002. The hospital is situated on the Gosport peninsula and has 113 beds. Together with outpatient services and a day hospital, there are beds for older people and maternity services. The hospital does not admit patients who are acutely ill and it has neither an A&E nor intensive care facilities. Portsmouth Healthcare NHS Trust provided a range of community and hospital based services for the people of Portsmouth, Fareham, Gosport and surrounding areas. These services included mental health (adult and elderly), community paediatrics, elderly medicine, learning disabilities and psychology.

3.5 The trust was one of the largest community trusts in the south of England and employed almost 5,000 staff. In 2001/2002 the trust had a budget in excess of £100 million and over 20% of income spent on its largest service, elderly medicine. All the trust's financial targets were met in 2000/2001.

Move towards the primary care trust

3.6 Portsmouth Healthcare NHS Trust was dissolved on 31 March 2002. Services have been transferred to local primary care trusts (PCTs), including Fareham and Gosport PCT, which became operational as a level four PCT in April 2002. Arrangements have been made for each PCT to host provider services on a district wide basis but each PCT retains responsibility for commissioning its share of district wide services from the host PCT. Fareham and Gosport PCT will manage many of the staff, premises and facilities of a number of sites, including the Gosport War Memorial Hospital. Medical staff involved in the care of older people, including those working at the Gosport War Memorial Hospital, are now employed by the East Hampshire PCT.

Portsmouth Healthcare NHS Trust strategic management

3.7 The trust board consisted of a chair, five non executive directors, the chief executive, the executive directors of operations, medicine, nursing and finance and the personnel director. The trust was organised into six divisions, two of which are relevant to this investigation. The Fareham and Gosport division, which managed the Gosport War Memorial Hospital, and the department of medicine for elderly people.

3.8 CHI heard that the trust was well regarded in the local health community and had developed constructive links with the health authority and local primary care groups (PCGs). For example, in the lead up to the formation of the new PCT, Portsmouth Healthcare NHS Trust's director of operations worked for two days each week for the East Hampshire PCT. Other examples included the joint work of the PCG and the trust on the development of intermediate care and clinical governance. High regard and respect for trust staff was also commented on by the local medical committee, Unison and the Royal College of Nursing.

Local services for older people

3.9 Before April 2002, access to medical beds for older people in Portsmouth (which included acute care, rehabilitation and continuing care) was managed through the department of medicine for elderly people which was managed by the Portsmouth Healthcare NHS Trust. Some of the beds were located in community hospitals such as the Gosport War Memorial Hospital, where the day to day general management of the hospital was the responsibility of the locality divisions of Portsmouth Healthcare NHS Trust. The Fareham and Gosport division of the trust fulfilled this role at the Gosport War Memorial Hospital.

3.10 The department of medicine for elderly people has now transferred to East Hampshire PCT. The nursing staff of the wards caring for older people at the Gosport War Memorial Hospital are now employed by the Fareham and Gosport PCT. Management of all services for older people has now transferred to the East Hampshire PCT.

3.11 General acute services were, and remain, based at Queen Alexandra and St Mary's hospitals, part of the Portsmouth Hospitals NHS Trust, the local acute trust. Though an unusual arrangement, a precedent for this model of care existed, for example in Southampton Community NHS Trust.

3.12 Until August 2001, the Royal Hospital Haslar, a Ministry of Defence military hospital on the Gosport peninsula, also provided acute medical care to civilians, many of whom were older people, as well as military staff.

Service performance management

3.13 Divisional management at Portsmouth Healthcare NHS Trust was well defined, with clear systems for reporting and monitoring. The quarterly divisional review was the principal tool for the performance management of the Fareham and Gosport division. The review considered regular reports on clinical governance, complaints and risk. Fareham and Gosport division was led by a general manager, who reported to the operational director. Leadership at Fareham and Gosport divisional level was strong with clear accounting structures to corporate and board level.

Inpatient services for older people at the Gosport War Memorial Hospital 1998-2002

3.14 Gosport War Memorial Hospital provides continuing care, rehabilitation, day hospital and outpatient services for older people and was managed by the Fareham and Gosport division. In November 2000, as a result of local developments to develop intermediate and rehabilitation services in the community, there was a change in the use of beds at the hospital to provide additional rehabilitation beds.

3.15 In 1998, three wards at Gosport War Memorial Hospital admitted older patients for general medical care: Dryad, Daedalus and Sultan. This is still the case in 2002.

Figure 3.1 Inpatient provision at Gosport War Memorial Hospital by ward

Ward	1998	2002
Dryad	20 continuing care beds. Patients admitted under the care of a consultant, with some day to day care provided by a clinical assistant.	20 continuing care beds for frail elderly patients and slow stream rehabilitation. Patients admitted under the care of a consultant. Day to day care is provided by a staff grade doctor.
Daedalus	16 continuing care beds and 8 for slow stream rehabilitation. Patients admitted under the care of a consultant, some day to day care provided by a clinical assistant.	24 rehabilitation beds: 8 general, 8 fast and 8 slow stream (since November 2000). Patients admitted under the care of a consultant. Day to day care provided by a staff grade doctor.
Sultan	24 GP beds with care managed by patients' own GPs. Patients were not exclusively older patients; care could include rehabilitation and respite care. A ward manager (or sister) managed the ward, which was staffed by Portsmouth Healthcare NHS Trust staff.	The situation is the same as in 1998, except that the nursing staff are now employed by Fareham and Gosport PCT.

Admission criteria

3.13 The current criteria for admission to both Dryad and Daedalus wards are that the patient must be over 65 and be registered with a GP within the Gosport PCG (now a part of Fareham and Gosport PCT). In addition, Dryad patients must have a Barthel score of under 4/20 and require specialist medical and nursing intervention. The Barthel score is a validated tool used to measure physical disability. Daedalus patients must need multidisciplinary rehabilitation, for example following a stroke.

3.14 There was, and still is, a comprehensive list of admission criteria for Sultan ward developed in 1999, all of which must be met prior to admission. The criteria state that patients must not be medically unstable and no intravenous lines must be in situ.

Elderly mental health

3.15 Although not part of the CHI investigation, older patients are also cared for on Mulberry ward, a 40 bed assessment unit comprising Collingwood and Ark Royal wards. Patients admitted to this ward are under the care of a consultant in elderly mental health.

Terminology

3.16 CHI found considerable confusion about the terminology describing the various levels of care for older people in written information and in interviews with staff. For example, the terms stroke rehab, slow stream rehab, very slow stream rehab, intermediate and continuing care were all used. CHI was not aware of any common local definition for these terms in use at the trust or of any national definitions. CHI stakeholder work confirmed that this confusion extended to patients and relatives in terms of their expectations of the type of care received.

KEY FINDINGS

1. Throughout the timeframe covered by the CHI investigation, CHI received evidence of strong leadership, with a shared set of values at corporate and divisional level in Portsmouth Healthcare NHS Trust. The senior management team was well established and, together with the trust board, functioned as a cohesive team. The chief executive was accessible to and well regarded by staff both within the trust and in the local health economy. Good links had been developed with local PCGs.

2. The case note review undertaken by CHI confirmed that the admission criteria for both Dryad and Daedalus wards were being adhered to over recent months and that patients were being appropriately admitted. However, CHI found examples of some recent patients who had been admitted to Sultan ward with more complex needs than stipulated in the admission criteria that may have compromised patient care.

3. 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 that had not been fulfilled.

RECOMMENDATIONS

1. Fareham and Gosport PCT and East Hampshire PCT should work together to build on the many positive aspects of leadership developed by Portsmouth Healthcare NHS Trust in order to develop the provision of care for older people at the Gosport War Memorial Hospital. The PCTs should ensure an appropriate performance monitoring tool is in place to ensure that any quality of care and performance shortfalls are identified and addressed swiftly.

2. Hampshire and Isle of Wight strategic health authority should use the findings of this investigation to influence the nature of local monitoring of the national service framework for older people.

3. Fareham and Gosport PCT and East Hampshire PCT should, in consultation with local GPs, review the admission criteria for Sultan ward.

4. The Department of Health should assist in the promotion of an NHS wide shared understanding of the various terms used to describe levels of care for older people.

4 | Arrangements for the prescription, administration, review and recording of medicines

Police inquiry and expert witness reports

4.1 CHI's terms of reference for its investigation in part reflected those of the earlier preliminary inquiry by the police, whose reports were made available to CHI.

4.2 Police expert witnesses reviewed the care of five patients who died in 1998 and made general comments in the reports about the systems in place at the trust to ensure effective clinical leadership and patient management on the wards. The experts' examination of the use of medicines in Daedalus, Dryad and Sultan wards led to significant concern about three medicines, the amounts which had been prescribed, the combinations in which they were used and the method of their delivery. In summary:

- there was no evidence of trust policy to ensure the appropriate prescription and dose escalation of strong opiate analgesia as the initial response to pain. It was the view of the police expert witnesses that a more reasonable response would have been the prescription of mild to moderate medicine initially with appropriate review in the event of further pain followed up
- there was inappropriate combined subcutaneous administration of diamorphine, midazolam and haloperidol, which could carry a risk of excessive sedation and respiratory depression in older patients, leading to death
- there were no clear guidelines available to staff to prevent assumptions being made by clinical staff that patients had been admitted for palliative, rather than rehabilitative care
- there was a failure to recognise potential adverse effects of prescribed medicines by clinical staff
- clinical managers failed to routinely monitor and supervise care on the ward

It is important to emphasise that these reports were not produced for this CHI investigation and CHI cannot take any responsibility for their accuracy. Whilst the reports provided CHI with very useful information, CHI has relied on its own independent scrutiny of data and information gathered during the investigation to reach the conclusions in this chapter.

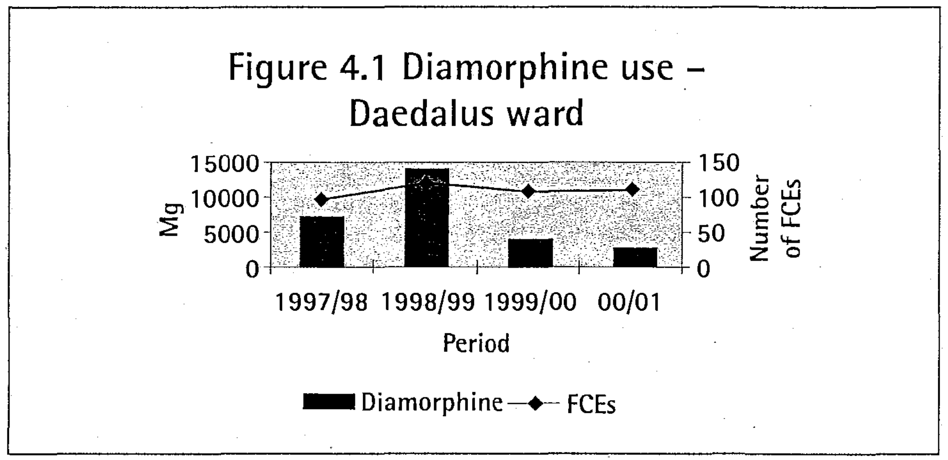
Medicine usage

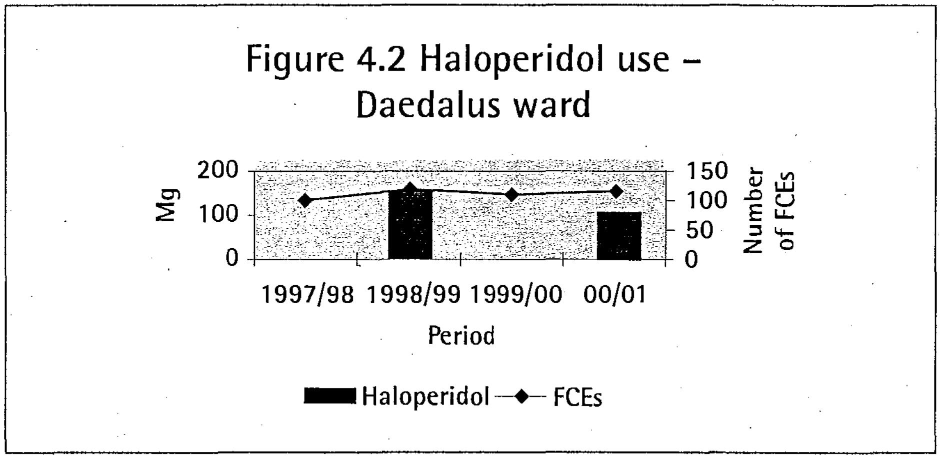
4.3 In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines issued from the pharmacy and does not include any wastage, nor can it verify the quantity of medicines administered to each patient. As the data does not offer any breakdown of casemix, it is not possible to determine how complex the needs of patients were in each year. Staff speaking to CHI described an increase in the numbers of sicker patients in recent years. A detailed breakdown of medicines issued to each ward is attached at appendix I.

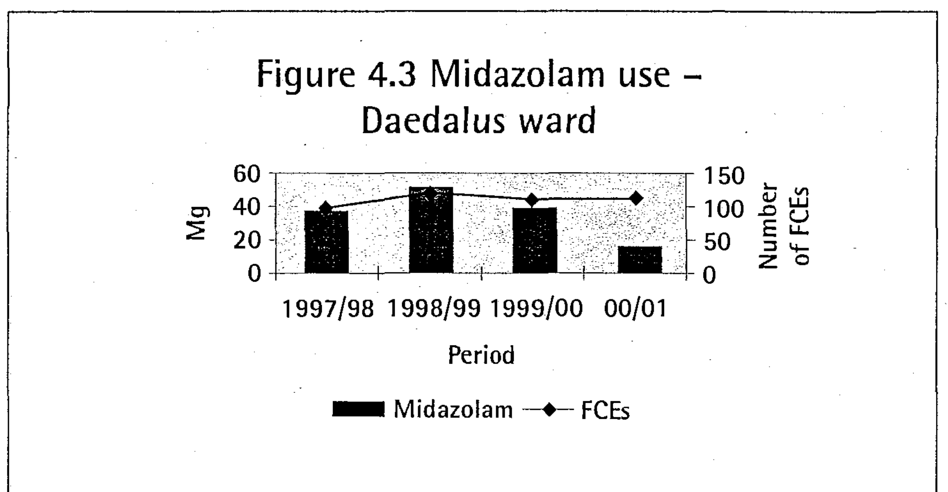
4.4 The experts commissioned by the police had serious concerns about the level of use of these three medicines (diamorphine, haloperidol and midazolam) and the apparent practice of anticipatory prescribing. CHI shares this view and believes the use and combination of medicines used in 1998 was excessive and outside normal practice. The following figures indicate the use of each medicine by ward and year, plotted alongside the number patients treated (finished consultant episodes).

4.5 The trust's own data, provided to CHI during the site visit week, illustrates a marked decline in the usage of diamorphine, haloperidol and midazolam in recent years. This decline has been most pronounced on Dryad ward and is against a rise in FCEs during the same timeframe. The trust's data demonstrates that usage of each of these medicines peaked in 1998/99. On Sultan ward, the use of haloperidol and midazolam have also declined in recent years with a steady increase in FCEs. Diamorphine use, after declining dramatically in 1999/00, showed an increase in 2000/01.

Medicine issued 1997/1998-2000/2001 according to the number of finished consultant episodes per ward, based on information provided by the Portsmouth Healthcare NHS Trust (see appendices H and I)







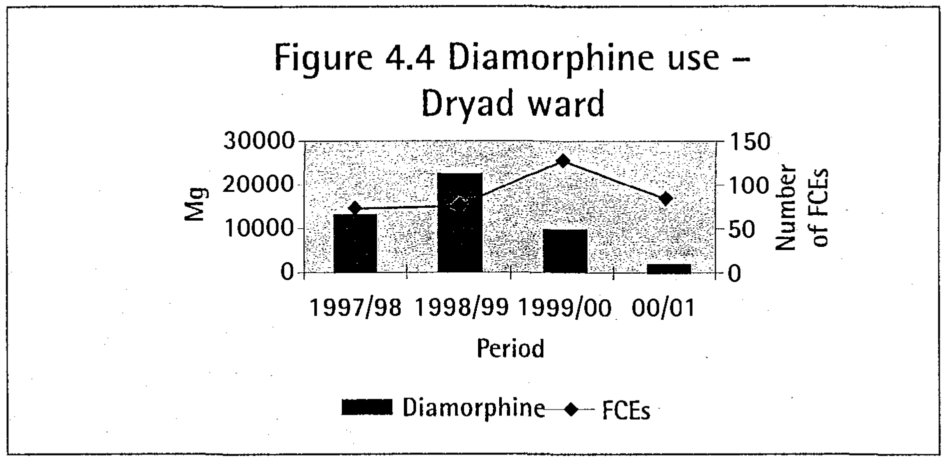


Figure 4.4 Diamorphine use -
Dryad ward
30000
20000
10000
0
Mg
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Diamorphine
FCEs

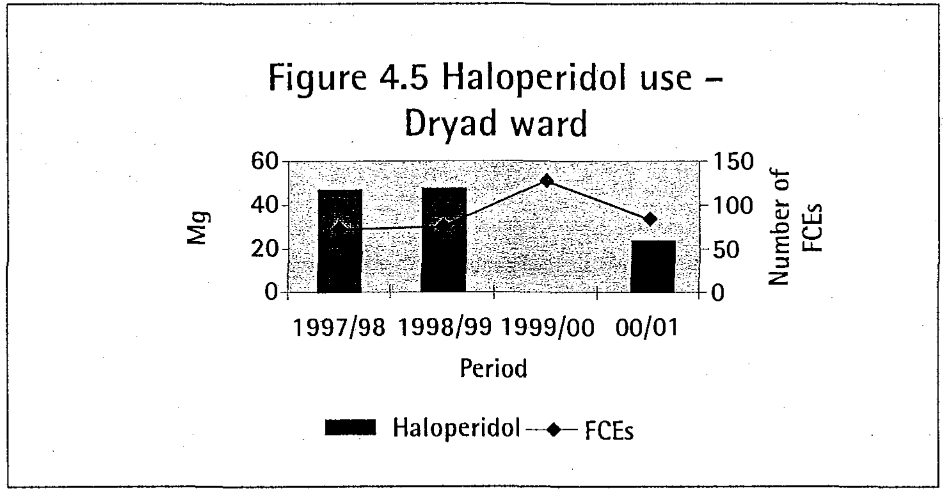


Figure 4.5 Haloperidol use -
Dryad ward
60
40
20
0
Mg
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Haloperidol
FCEs

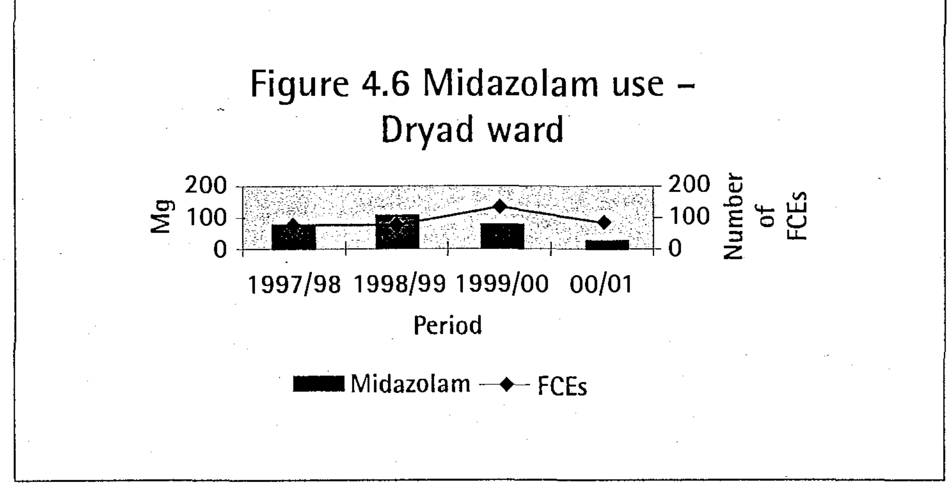


Figure 4.6 Midazolam use -
Dryad ward
200
100
0
Mg
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Midazolam
FCEs

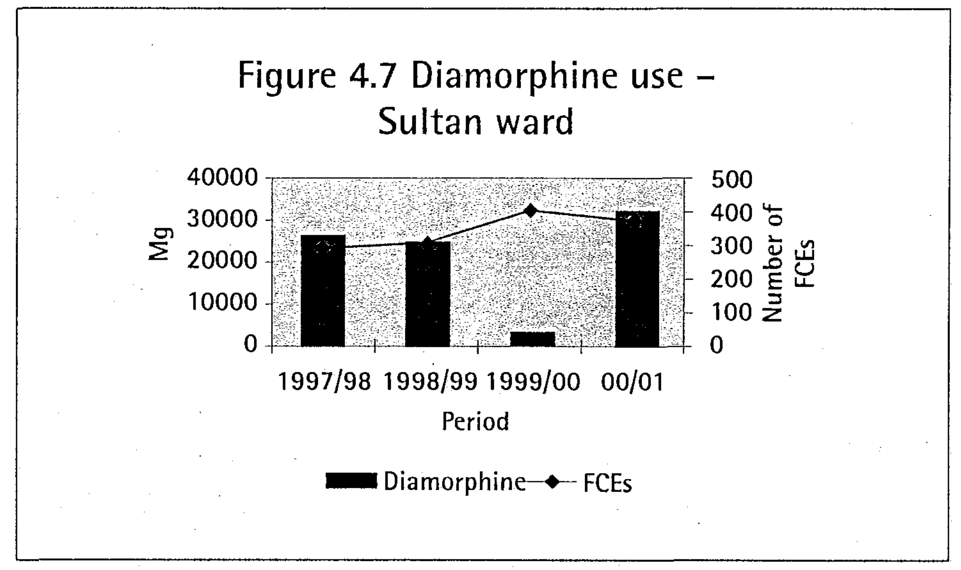


Figure 4.7 Diamorphine use -
Sultan ward
40000
30000
20000
10000
0
Mg
500
400
300
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Diamorphine
FCEs

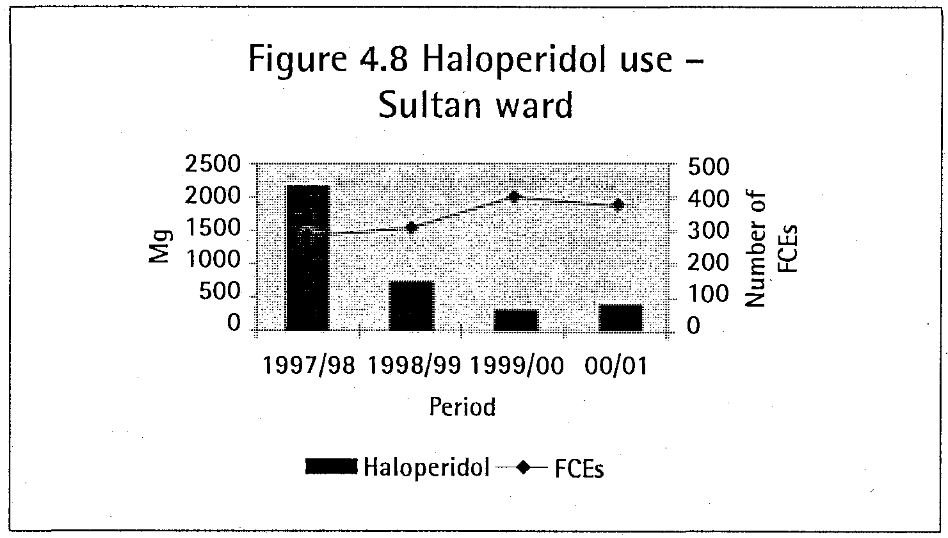


Figure 4.8 Haloperidol use -
Sultan ward
2500
2000
1500
1000
500
0
Mg
500
400
300
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Haloperidol
FCEs

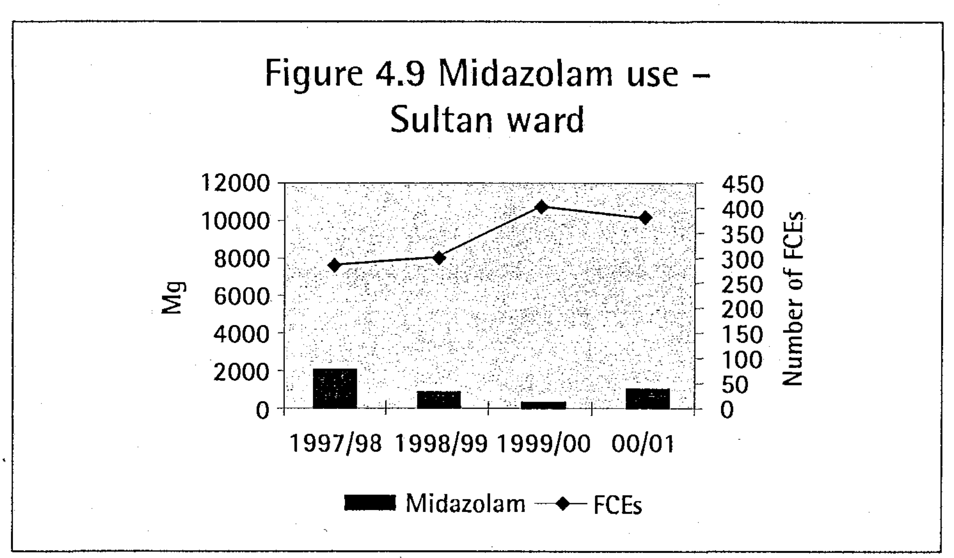


Figure 4.9 Midazolam use -
Sultan ward
12000
10000
8000
6000
4000
2000
0
Mg
450
400
350
300
250
200
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Midazolam
FCEs

Assessment and management of pain

4.6 Part of the individual total assessment of each patient includes an assessment of any pain they may be experiencing and how this is to be managed. In 1998, the trust did not have a policy for the assessment and management of pain. This was introduced in April 2001, in collaboration with Portsmouth Hospitals NHS Trust, and is due for review in 2003. The stated purpose of the document was to identify mechanisms to ensure that all patients have early and effective management of pain or distress. The policy placed responsibility for ensuring that pain management standards are implemented in every clinical setting and sets out the following:

- the prescription must be written by medical staff following diagnosis of type(s) of pain and be appropriate given the current circumstances of the patient
- if the prescription states that medication is to be administered by continuous infusion (syringe driver), the rationale for this decision must be clearly documented
- all prescriptions for drugs administered via a syringe driver must be written on a prescription sheet designed for this purpose

4.7 CHI has also seen evidence of a pain management cycle chart and an 'analgesic ladder'. The analgesic ladder indicates the drug doses for different levels and types of pain, how to calculate opiate doses, gives advice on how to evaluate the effects of analgesia and how to observe for any side effects. Nurses interviewed by CHI demonstrated a good understanding of pain assessment tools and the use of the analgesic ladder.

4.8 CHI was told by some nursing staff that following the introduction of the policy, it took longer for some patients to become pain free and that medical staff were apprehensive about prescribing diamorphine. Nurses also spoke of a reluctance of some patients to take pain relief. CHI's case note review concluded that two of the 15 patients reviewed were not prescribed adequate pain relief for part of their stay in hospital.

4.9 Many staff interviewed referred to the "Wessex guidelines". This is a booklet called *Palliative care handbook guidelines on clinical management* drawn up by Portsmouth Healthcare NHS Trust, the Portsmouth Hospitals NHS Trust and a local hospice, in association with the Wessex palliative care units. These guidelines were in place in 1998. Although the section on pain focuses on patients with cancer, there is a clear highlighted statement in the guidelines that states "all pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold".

4.10 The Wessex guidelines are comprehensive and include detail, in line with British National Formulary recommendations, on the use, dosage, and side effects of medicines commonly used in palliative care. The guidelines are not designed for a rehabilitation environment.

4.11 CHI's random case note review of 15 recent admissions concluded that the pain assistance and management policy is being adhered to. CHI was told by staff of the previous practice of anticipatory prescribing of palliative opiates. As a result of the pain and assessment policy, this practice has now stopped.

Prescription writing policy

4.12 This policy was produced jointly with the Portsmouth Hospitals NHS Trust in March 1998. The policy covered the purpose, scope, responsibilities and requirements for prescription writing, medicines administered at nurses' discretion and controlled drugs. A separate policy covers the administration of intravenous medicines.

4.13 The policy has a section on verbal prescription orders, including telephone orders, in line with UKCC guidelines. CHI understands that arrangements such as these are common practice in GP led wards and work well on the Sultan ward, with arrangements in place for GPs to sign the prescription within 12 hours. These arrangements were also confirmed by evidence found in CHI's case note review.

Administration of medicines

4.14 Medicines can be administered in a number of ways, for example, orally in tablet or liquid form, by injection and via a syringe driver. Some of the medicines used in the care of older people can be delivered by a syringe driver, which delivers a continuous subcutaneous infusion of medication. Syringe drivers can be an entirely appropriate method of medicine administration that provides good control of symptoms with little discomfort or inconvenience to the patient. Guidance for staff on prescribing via syringe drivers is contained within the trust's policy for assessment and management of pain. The policy states that all prescriptions for continuous infusion must be written on a prescription sheet designed for this purpose.

4.15 Evidence from CHI's case note review demonstrated good documented examples of communication with both patients and relatives over medication and the use of syringe drivers and the application of the trust's policy.

4.16 Information provided by the trust indicates that only two qualified nurses from Sultan ward had taken part in a syringe driver course in 1999. Five nurses had also completed a drugs competencies course. No qualified nurses from Dryad or Daedalus ward had taken part in either course between 1998 and 2001. Some nursing and healthcare support staff spoke of receiving syringe driver information and training from a local hospice.

Role of nurses in medicines administration

4.17 Registered nurses are regulated by the Nursing and Midwifery Council, a new statutory body which replaced the United Kingdom Central Council on 1 April 2002. Registered nurses must work within their code of professional conduct (UKCC, June 1992). The scope of professional practice clarified the way in which registered nurses are personally accountable for their own clinical practice and for care they provide to patients. The standards for the administration of medicines (UKCC, October 1992) details what is expected of nurses carrying out this function.

4.18 Underpinning all of the regulations that govern nursing practice, is the requirement that nurses act in the best interest of their patients at all times. This could include challenging the prescribing of other clinical staff.

Review of medicines

4.19 The regular ward rounds and multidisciplinary meetings should include a review of medication by senior staff, which is recorded in the patient's case notes. CHI recognises the complexity of multidisciplinary meetings. Despite this, a process should be found to ensure that effective and regular reviews of patient medication take place by senior clinicians and pharmacy staff.

Structure of pharmacy

4.20 Portsmouth Healthcare NHS Trust has a service level agreement for pharmacy services with the local acute trust, Portsmouth Hospitals NHS Trust. An E grade pharmacist manages the contract locally and the service provided by a second pharmacist, who is the lead for older peoples' services. Pharmacists speaking to CHI spoke of a remote relationship between the community hospitals and the main pharmacy department at Queen Alexandra Hospital, together with an increasing workload. Pharmacy staff were confident that ward pharmacists would now challenge large doses written up by junior doctors but stressed the need for a computerised system which would allow clinician specific records. There are some recent plans to put the trust's *A compendium of drug therapy guidelines* on the intranet, although this is not easily available to all staff.

4.21 Pharmacy training for non pharmacy staff was described as "totally inadequate" and not taken seriously. Nobody knew of any training offered to clinical assistants.

4.22 There were no systems in place in 1998 for the routine review of pharmacy data which could have alerted the trust to any unusual or excessive patterns of prescribing, although the prescribing data was available for analysis.

KEY FINDINGS

1. 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 (the "Wessex guidelines") but this was inappropriately applied to patients admitted for rehabilitation.

2. 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.

3. The usage of diamorphine, midazolam and haloperidol has declined in recent years, reinforced by trust staff interviewed by CHI and by CHI's own review of recent case notes. Nursing staff interviewed confirmed the decreased use of both diamorphine and the use of syringe drivers since 1998.

4. CHI found some evidence to suggest a recent reluctance amongst clinicians to prescribe sufficient pain relieving medication. Despite this, diamorphine usage on Sultan ward 2000/2001 showed a marked increase.

5. CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Anticipatory prescribing is no longer evident on these wards. 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.

6. CHI found little evidence to suggest that thorough individual total patient assessments were being made by multidisciplinary teams in 1998. CHI's case note review concluded that this approach to care had been developed in recent years.

7. Pharmacy support to the wards in 1998 was inadequate. The trust was able to produce pharmacy data in 2002 relating to 1998. A system should have been in place to review and monitor prescribing at ward level, using data such as this as a basis.

RECOMMENDATIONS

1. As a priority, the Fareham and Gosport PCT must ensure that a system is in place to routinely review and monitor prescribing of all medicines on wards caring for older people. This should include a review of recent diamorphine prescribing on Sultan ward. Consideration must be given to the adequacy of IT support available to facilitate this.

2. The East Hampshire PCT and Fareham and Gosport PCT should review all local prescribing guidelines to ensure their appropriateness for the current levels of dependency of the patients on the wards.

3. The Fareham and Gosport PCT should review the provision of pharmacy services to Dryad, Daedalus and Sultan wards, taking into account the change in casemix and use of these wards in recent years. Consideration should be given to including pharmacy input into regular ward rounds.

4. The Fareham and Gosport PCT and East Hampshire PCT, in conjunction with the pharmacy department, must ensure that all relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people.

5 | Quality of care and the patient experience

Introduction

5.1 This chapter details CHI's findings following contact with patients and relatives. This needs to be put into the context of the 1,725 finished consultant episodes for older patients admitted to the Gosport War Memorial Hospital between April 1998 and March 2001. Details of the methods used to gain an insight into the patient experience and of the issues raised with CHI are contained in appendix B.

Patient expeience

5.2 As with all patients being cared for when they are sick and vulnerable, it is important to treat each person as a whole. For this reason, the total holistic assessment of patients is critical to high quality individual care tailored to each patient's specific needs. The following sections are key elements (though not an exhaustive list) of total assessments which were reported to CHI by stakeholders.

5.3 CHI examined in detail the experience of older patients admitted to the Gosport War Memorial Hospital between 1998 and 2001 and that of their relatives and carers. This was carried out in two ways. Firstly, stakeholders were invited, through local publicity, to make contact with CHI. The police also wrote to relatives who had expressed concern to them informing them of CHI's investigation. Views were invited in person, in writing, over the telephone and by questionnaire. A total of 36 patients and relatives contacted CHI during the investigation.

5.4 Secondly, CHI made a number of observation visits, including at night, to Daedalus, Dryad and Sultan wards during the site visit week in January 2002. Some of the visits were unannounced. Mealtimes, staff handovers, ward rounds and medicine rounds were observed.

Stakeholder views

5.5 The term stakeholder is used by CHI to define a range of people that are affected by, or have an interest in, the services offered by an organisation. CHI heard of a range of both positive and less positive experiences, of the care of older people. The most frequently raised concerns with CHI were: the use of medicines, the attitude of staff, continence management, the use of patients' own clothing, transfer arrangements between hospitals and nutrition and fluids. More detail on each of these areas is given below.

5.6 Relatives expressed concern around a perceived lack of nutrition and fluids as patients neared the end of their lives: "no water and fluids for last four days of life". Comments were also raised about unsuitable, unappetising food and patients being left to eat without assistance. A number of stakeholders commented on untouched food being cleared away without patients being given assistance to eat.

5.7 Following comments by stakeholders, CHI reviewed the trust policy for nutrition and fluids. The trust conducted a trust wide audit of minimum nutritional standards between October 1997 and March 1998, as part of the five year national strategy *Feeding People*. The trust policy, *Prevention and management of malnutrition* (2000), included the designation of an appropriately trained lead person in each clinical area, who would organise training programmes for staff and improve documentation to ensure full compliance. The standards state:

- all patients must have a nutritional risk assessment on admission
- registered nurses must plan, implement and oversee nutritional care and refer to an appropriate professional as necessary
- all staff must ensure that documented evidence supports the continuity of patient care and clinical practice
- all clinical areas should have a nominated nutritional representative who attends training/updates and is a resource for colleagues
- systems should be in place to ensure that staff have the required training to implement and monitor the *Feeding People* standards

5.8 A second trust audit in 2000 concluded that, overall, the implementation of the *Feeding People* standards had been "very encouraging". However, there were concerns about the lack of documentation and a sense of complacency as locally written protocols had not been produced throughout the service.

5.9 CHI's review of recent case notes concluded that appropriate recording of patient intake and output was taking place. CHI was concerned that nurses appeared unable to make swallowing assessments out of hours; this could lead to delays in receiving nutrition over weekends, for example, when speech and language therapy staff were not available.

5.10 Continence management is an important aspect of the care of older people, the underlying objective is to promote or sustain continence as part of the holistic management of care, this includes maintaining skin integrity (prevention of pressure sores). Where this is not possible, a range of options including catheterisation are available and it is imperative that these are discussed with patients, relatives and carers. Some stakeholders raised concerns regarding the 'automatic' catheterisation of patients on admission to the War Memorial. "They seem to catheterise everyone. My husband was not incontinent; the nurse said it was done mostly to save time". Relatives also spoke of patients waiting for long periods of time to be helped to the toilet or for help in using the commode.

5.11 CHI's review of recent case notes found no evidence of inappropriate catheterisation of patients in recent months.

5.12 The use of pain relieving medicines and the use of syringe drivers to administer them was commented on by a number of relatives. One relative commented that her mother "certainly was not in pain prior to transfer to the War Memorial". Although a number of relatives confirmed that staff did speak to them before medication was delivered by a syringe driver, CHI also received comments that families would have liked more information: "Doctors should disclose all drugs, why [they are being used] and what the side effects are. There should be more honesty".

5.13 Many relatives were distressed about patients who were not dressed in their own clothes, even when labelled clothes had been provided by their families. "They were never in their own clothes". Relatives also thought patients being dressed in other patients' clothes was a potential cross infection risk. The trust did apologise to families who had raised this as a complaint and explained the steps taken by wards to ensure patients were dressed in their own clothes. This is an important means by which patients' dignity can be maintained.

5.14 Concern was expressed regarding the physical transfer of patients from one hospital to another. Amongst concerns were lengthy waits prior to transfer, inadequate clothing and covering during the journey and the methods used to transfer patients. One person described their relative as being "carried on nothing more than a sheet". CHI learnt that this instance was acknowledged by Portsmouth Healthcare NHS Trust, who sought an apology from the referring hospital, which did not have the appropriate equipment available.

5.15 Though there were obvious concerns regarding the transfer of patients, during the period of the investigation, the Hampshire Ambulance Service NHS Trust, who were responsible for patient transfers between hospitals, received no complaints relating to the transfer of patients to and from the Gosport War Memorial Hospital.

5.16 Comments about the attitude of staff ranged from the very positive "Everyone was so kind and caring towards him in both Daedalus and Dryad wards" and "I received such kindness and help from all the staff at all times" to the less positive "I was made to feel an inconvenience because we asked questions" and "I got the feeling she had dementia and her feelings didn't count".

Outcome of CHI observation work

5.17 CHI spent time on Dryad, Sultan and Daedalus wards throughout the week of 7 January 2002 to observe the environment in which care was given, the interactions between staff and patients and between staff. Ward staff were welcoming, friendly and open. Although CHI observed a range of good patient experiences this only provides a 'snap shot' during the site visit and may not be fully representative. However, many of the positive aspects of patient care observed were confirmed by CHI's review of recent patient notes.

Ward environment

5.18 All wards were built during the 1991 expansion of the hospital and are modern, welcoming and bright. This view was echoed by stakeholders, who were complimentary about the décor and patient surroundings. Wards were tidy, clean and fresh smelling.

5.19 Day rooms are pleasant and Daedalus ward has direct access to a well designed garden suitable for wheelchair users. The garden is paved with a variety of different textures to enable patients to practice mobility. There is limited storage space in Daedalus and Dryad wards and, as a result, the corridors had become cluttered with equipment. This can be problematic for patients using walking aids. Daedalus ward has an attractive, separate single room for independent living assessment with its own sink and wardrobe.

5.20 CHI saw staff address patients by name in a respectful and encouraging way and saw examples of staff helping patients with dressing and holding friendly conversations. The staff handovers observed were well conducted, held away from the main wards areas and relevant information about patient care was exchanged appropriately.

5.21 Mealtimes were well organised with patients given a choice of menu options and portion size. Patients who needed help to eat and drink were given assistance. There appeared to be sufficient staff to serve meals, and to note when meals were not eaten. CHI did not observe any meals returned untouched. Healthcare support workers told CHI that they were responsible for making a note when meals were not eaten.

5.22 There are day rooms where patients are able to watch the television and large print books, puzzles and current newspapers are provided. CHI saw little evidence of social activities taking place, although some patients did eat together in the day room. Bells to call assistance are situated by patients' beds, but are less accessible to patients in the day rooms. The wards have an activities coordinator, although the impact of this post has been limited.

5.23 Daedalus ward has a communication book by each bed for patients and relatives to make comments about day to day care. This is a two way communication process which, for example, allows therapy staff to ask relatives for feedback on progress and enables relatives to ask for an appointment with the consultant.

5.24 CHI observed two medicine rounds, both of which were conducted in an appropriate way with two members of staff jointly identifying the patient and checking the prescription sheet. One member of staff handed out the medicines while the other oversaw the patients as medicines are taken. Medicines are safely stored on the wards in locked cupboards.

Communication with patients, relatives and carers

The trust had an undated user involvement service development framework, which sets out the principles behind effective user involvement within the national policy framework described in the NHS Plan. It is unclear from the framework who was responsible for taking the work forward and within what time frame. Given the dissolution of the trust, a decision was taken not to establish a trust wide Patient Advice and Liaison Service (PALS), a requirement of the NHS Plan. However, work was started by the trust to look at a possible future PALS structure for the Fareham and Gosport PCT.

The Health Advisory Service *Standards for health and social care services for older people* (2000) states that "each service should have a written information leaflet or guide for older people who use the service. There should be good information facilities in inpatient services for older people, their relatives and carers". CHI saw a number of separate information leaflets provided for patients and relatives during the site visit.

The trust used patient surveys, given to patients on discharge, as part of its patient involvement framework, although the response rate was unknown. Issues raised by patients in completed surveys were addressed by action plans discussed at clinical managers meetings. Ward specific action plans were distributed to ward staff. CHI noted, for example, that as a result of patient comments regarding unacceptable ward temperatures, thermometers were purchased to address the problem. CHI could find no evidence to suggest that the findings from patient surveys were shared across the trust.

Support towards the end of life

Staff referred to the Wessex palliative care guidelines, which are used on the wards and address breaking bad news and communicating with the bereaved. Many clinical staff, at all levels spoke of the difficulty in managing patient and relative expectations following discharge from the acute sector. "They often painted a rosier picture than justified". Staff spoke of the closure of the Royal Haslar acute beds leading to increased pressure on Queen Alexandra and St Mary's hospitals to "discharge patients too quickly to Gosport War Memorial Hospital". Staff were aware of increased numbers of medically unstable patients being transferred in recent years.

Both patients and relatives have access to a hospital chaplain, who has links to representatives of other faiths. The trust had a leaflet for relatives *Because we care* which talks about registering the death, bereavement and grieving. The hospital has a designated manager to assist relatives through the practical necessities following a death.

KEY FINDINGS

1. 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.

2. Based on CHI's observation work and review of recent case notes, CHI has no significant concerns regarding the standard of nursing care provided to the patients of Daedalus, Dryad and Sultan ward now.

3. The ward environments and patient surroundings are good.

4. Some notable steps had been taken on Daedalus ward to facilitate communication between patients and their relatives with ward staff.

5. CHI was concerned, following the case note review, of the inability of any ward staff to undertake swallowing assessments as required. This is an area of potential risk for patients whose swallowing reflex may have been affected, for example, by a stroke.

6. Opportunities for patients to engage in daytime activities in order to encourage orientation and promote confidence are limited.

7. The trust had a strong theoretical commitment to patient and user involvement.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. All patient complaints and comments, both informal and formal, should be used at ward level to improve patient care. The Fareham and Gosport PCT and East Hampshire PCT must ensure a mechanism is in place to ensure that shared learning is disseminated amongst all staff caring for older people.

2. Fareham and Gosport PCT should lead an initiative to ensure that relevant staff are appropriately trained to undertake swallowing assessments to ensure that there are no delays out of hours.

3. Daytime activities for patients should be increased. The role of the activities coordinator should be revised and clarified, with input from patients, relatives and all therapists in order that activities complement therapy goals.

4. The Fareham and Gosport PCT must ensure that all local continence management, nutrition and hydration practices are in line with the national standards set out in the *Essence of Care* guidelines.

5. Within the framework of the new PALS, the Fareham and Gosport PCT should, as a priority, consult with user groups and consider reviewing specialist advice from national support and patient groups, to determine the best way to improve communication with older patients and their relatives and carers.

6 | Staffing arrangements and responsibility for patient care

Responsibility for patient care

6.1 Patient care on Daedalus and Dryad wards at Gosport War Memorial Hospital for the period of the CHI investigation was provided by consultant led teams. A multidisciplinary, multiprofessional team of appropriately trained staff best meets the complex needs of these vulnerable patients. This ensures that the total needs of the patient are considered and are reflected in a care plan, which is discussed with the patient and their relatives and is understood by every member of the team.

Medical responsibility

6.2 For the period covered by the CHI investigation, medical responsibility for the care of older people in Daedalus and Dryad wards lay with the named consultant of each patient. This is still the case today. All patients on both wards are admitted under the care of a consultant. Since 1995, there has been a lead consultant for the department of medicine for elderly people who held a two session contract (one session equates to half a day per week) for undertaking lead consultant responsibilities. These responsibilities included overall management of the department and the development of departmental objectives. The lead consultant is not responsible for the clinical practice of individual doctors. The post holder does not undertake any clinical sessions on the War Memorial site. The job description for the post, outlines 12 functions and states that the post is a major challenge for "a very part time role".

6.3 Since 2000, two department of elderly medicine consultants provide a total of 10 sessions of consultant cover on Dryad and Daedalus wards per week. Since September 2000, day to day medical support has been provided by a staff grade physician who was supervised by both consultants. Until July 2000, a clinical assistant provided additional medical support. Both consultants currently undertake a weekly ward round with the staff grade doctor. In 1998, there was a fortnightly ward round on Daedalus ward. On Dryad, ward rounds were scheduled fortnightly, though occurred less frequently.

6.4 CHI feels that the staff grade post is a pivotal, potentially isolated post, due to the distance of Gosport War Memorial Hospital from the main department of medicine for elderly people based at Queen Alexandra Hospital, no full time support from medical colleagues on the wards and a difficulty in attending departmental meetings. In 2001, the trust identified the risk of professional isolation and lack of support at Gosport War Memorial Hospital as a reason not to appoint a locum consultant.

Figure 6.1 Line management accountabilities

(*-------------- this line indicates managerial accountability and not clinical accountability)

General practice role and accountability

6.5 Local GPs worked at the Gosport War Memorial Hospital in three capacities during the period under investigation: as clinical assistants employed by the trust, as the clinicians admitting and caring for patients on the GP ward (Sultan) and as providers of out of hours medical support to all patients on each of the three wards.

Clinical assistant role

6.6 Clinical assistants are usually GPs employed and paid by trusts, largely on a part time basis, to provide medical support on hospital wards. Clinical assistants have been a feature of community hospitals within the NHS for a number of years. Portsmouth Healthcare NHS Trust employed a number of such GPs in this capacity in each of their community hospitals. Clinical assistants work as part of a consultant led team and have the same responsibilities as hospital doctors to prescribe medication, write in the medical record and complete death certificates. Clinical assistants should be accountable to a named consultant.

6.7 From 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states that the clinical assistant was accountable to "named consultant physicians in geriatric medicine". The post holder was responsible for arranging cover for annual leave and any sickness absence with practice partners. The trust and the practice partners did not have a contract for this work. The job description does state that the post is subject to the terms and conditions of hospital medical and dental staff. Therefore, any concerns over the performance of any relevant staff could be pursued through the trust's disciplinary processes. CHI could find no evidence to suggest that this option was considered at the time of the initial police investigation in 1998.

Appraisal and supervision of clinical assistants

6.8 CHI is not aware of any trust systems in place to monitor or appraise the performance of clinical assistants in 1998. This lack of monitoring is still common practice within the NHS. The consultants admitting patients to Dryad and Daedalus wards, to whom the clinical assistant was accountable, had no system for supervising the practice of the clinical assistant, including any review of prescribing. CHI found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Staff interviewed commented on the long working hours of the clinical assistant, in excess of the five contracted sessions.

6.9 CHI is aware of work by the Department of Health on GP appraisal which will cover GPs working as clinical assistants and further work to develop guidance on disciplinary procedures.

Sultan ward

6.10 Medical responsibility for patients on Sultan ward lay with the admitting GP throughout the period of the CHI investigation. The trust issued admitting GPs with a contract for working on trust premises, which clearly states "you will take full clinical responsibility for the patients under your care". CHI was told that GPs visit their patients regularly as well as when requested by nursing staff. This is a common arrangement in community hospitals throughout the NHS. GPs had no medical accountablity framework within the trust.

6.11 GPs managing their own patients on Sultan ward could be subject to the health authority's voluntary process for dealing with doctors whose performance is giving cause for concern. However, this procedure can only be used in regard to their work as a GP, and not any contracted work performed in the trust as a clinical assistant. Again, this arrangement is common throughout the NHS.

Out of hours cover provided by GPs

6.12 Between the hours of 8.30am and 5.00pm on weekdays, hospital doctors employed by the trust manage the care of all patients on Dryad and Daedalus wards. Out of hours medical cover, including weekends and bank holidays, is provided by a local GP practice from 5.00pm to 11.00pm, after which, between 11.00pm and 8.30am, nursing staff call on either the patient's practice or Healthcall, a local deputising service for medical input. If an urgent situation occurs out of hours, staff call 999 for assistance.

6.13 Some staff interviewed by CHI expressed concern about long waits for the deputising service, CHI heard that waiting times for Healthcall to attend a patient could sometimes take between three and five hours. However, evidence provided by Healthcall contradicts this. Nurses expressed concern over Healthcall GPs' reluctance to 'interfere' with the prescribing of admitting GPs on Sultan and Dryad wards. The contract with Healthcall is managed by a local practice.

Appraisal of hospital medical staff

6.14 Since April 2000, all NHS employers have been contractually required to carry out annual appraisals, covering both clinical and non clinical aspects of their jobs. All doctors interviewed by CHI who currently work for the trust, including the medical director, who works five sessions in the department of medicine for elderly people, have regular appraisals. Those appraising the work of other doctors have been trained to do so.

Nursing responsibility

6.15 All qualified nurses are personally accountable for their own clinical practice. Their managers are responsible for implementing systems and environments that promote high quality nursing care.

6.16 On each ward, a G grade clinical manager, who reports to a senior H grade nurse, manages the ward nurses. The H grade nurse covers all wards caring for older people and was managed by the general manager for the Fareham and Gosport division. The general manager reported to both the director of nursing and the operations director. An accountability structure such as this is not unusual in a community hospital. The director of nursing was ultimately accountable for the standard of nursing practice within the hospital.

Nursing supervision

6.17 Clinical supervision for nurses was recommended by the United Kingdom Central Council in 1996 and again in the national nursing strategy, *Making a difference*, in 1999. It is a system through which qualified nurses can maintain lifelong development and enhancement of their professional skills through reflection, exploration of practice and identification of issues that need to be addressed. Clinical supervision is not a

managerial activity, but provides an opportunity to reflect and improve on practice in a non judgemental environment. Clinical supervision is a key factor in professional self regulation.

6.18 The trust has been working to adopt a model of clinical supervision for nurses for a number of years and received initial assistance from the Royal College of Nursing to develop the processes. As part of the trust's clinical nursing development programme, which ran between January 1999 and December 2000, nurses caring for older people were identified to lead the development of clinical supervision on the wards.

6.19 Many of the nurses interviewed valued the principles of reflective practice as a way in which to improve their own skills and care of patients. The H grade senior nurse coordinator post, appointed in November 2000, was a specific trust response to an acknowledged lack of nursing leadership at the Gosport War Memorial Hospital.

Teamworking

6.20 Caring for older people involves input from many professionals who must coordinate their work around the needs of the patient. Good teamwork provides the cornerstone of high quality care for those with complex needs. Staff interviewed by CHI spoke of teamwork, although in several instances this was uniprofessional, for example a nursing team. CHI observed a multidisciplinary team meeting on Daedalus ward, which was attended by a consultant, a senior ward nurse, a physiotherapist and an occupational therapist. No junior staff were present. Hospital staff described input from social services as good when available, though this was not always the case.

6.21 Regular ward meetings are held on Sultan and Daedalus wards. Arrangements are less clear on Dryad ward, possibly due to the long term sickness of senior ward staff.

6.22 Arrangements for multidisciplinary team meetings on Dryad and Sultan wards are less well established. Occupational therapy staff reported some progress towards multidisciplinary goal setting for patients, but were hopeful of further development.

Allied health professional structures

6.23 Allied health professionals are a group of staff which include occupational therapists, dieticians, speech and language therapists and physiotherapists. The occupational therapy structure is in transition from a traditional site based service to a defined clinical specialty service (such as stroke rehabilitation) in the locality. Staff explained that this system enables the use of specialist clinical skills and ensures continuity of care of patients, as one occupational therapist follows the patient throughout hospital admission(s) and at home. Occupational therapists talking to CHI described a good supervision structure, with supervision contracts and performance development plans in place.

6.24 Physiotherapy services are based within the hospital. The physiotherapy team sees patients from admission right through to home treatment. Physiotherapists described good levels of training and supervision and involvement in Daedalus ward's multidisciplinary team meetings.

6.25 Speech and language therapists also reported participation in multidisciplinary team meetings on Daedalus ward. Examples were given to CHI of well developed in service training opportunities and professional development, such as discussion groups and clinical observation groups.

6.26 The staffing structure in dietetics consists of one full time dietitian based at St James Hospital. Each ward has a nurse with lead nutrition responsibilities able to advise colleagues.

Workforce and service planning

6.27 In November 2000, in preparation for the change of use of beds in Dryad and Daedalus wards from continuing care to intermediate care, the trust undertook an undated resource requirement analysis and identified three risk issues:

- consultant cover
- medical risk with a change in patient group and the likelihood of more patients requiring specialist intervention. The trust believed that the introduction of automated defibrillators would go some way to resolve this. The paper also spoke of "the need for clear protocols...within which medical cover can be obtained out of hours"
- the trust identified a course for qualified nursing staff, ALERT, which demonstrates a technique for quickly assessing any changes in a patients condition in order to provide an early warning of any deterioration

6.28 Despite this preparation, several members of staff expressed concern to CHI regarding the complex needs of many patients cared for at the Gosport War Memorial Hospital and spoke of a system under pressure due to nurse shortages and high sickness levels. Concerns were raised formally with the trust in early 2000 around the increased workload and complexity of patients. This was acknowledged in a letter by the medical director. CHI found no evidence of a systematic attempt to review or seek solutions to the evolving casemix, though a full time staff grade doctor was in post by September 2002 to replace and increase the previous five sessions of clinical assistant cover.

Access to specialist advice

6.29 Older patients are admitted to Gosport War Memorial Hospital with a wide variety of physical and mental health conditions, such as strokes, cancers and dementia. Staff demonstrated good examples of systems in place to access expert opinion and assistance.

6.30 There are supportive links with palliative care consultants, consultant psychiatrists and oncologists. The lead consultant for elderly mental health reported close links with the three wards, with patients either given support on the ward or transfer to an elderly mental health bed. There are plans for a nursing rotation

programme between the elderly medicine and elderly mental health wards. Staff spoke of strong links with the local hospice and Macmillan nurses. Nurses gave recent examples of joint training events with the hospice.

6.31 CHI's audit of recent case notes indicated that robust systems are in place for both specialist medical advice and therapeutic support.

Staff welfare

6.32 Since its creation in 1994, the trust developed as a caring employer, demonstrated by support for further education, flexible working hours and a ground breaking domestic violence policy that has won national recognition. The hospital was awarded Investors in People status in 1998. Both trust management and staff side representatives talking to CHI spoke of a constructive and supportive relationship.

6.33 However, many staff, at all levels in the organisation, spoke of the stress and low morale caused by the series of police investigations and the referrals to the General Medical Council, the United Kingdom Central Council and the CHI investigation. Trust managers told CHI they encouraged staff to use the trust's counselling service and support sessions for staff were organised. Not all staff speaking to CHI considered that they had been supported by the trust, particularly those working at a junior level, "I don't feel I've had the support I should have had before and during the police investigation – others feel the same".

Staff communication

6.34 Most staff interviewed by CHI spoke of good internal communications, and were well informed about the transfer of services to PCTs. The trust used newsletters to inform staff of key developments. An intranet is being developed by the Fareham and Gosport PCT to facilitate communication with staff.

KEY FINDINGS

1. Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards. It was not made clear to CHI how GPs working as clinical assistants and admitting patients to Sultan wards are included in the development of trust procedures and clinical governance arrangements.

2. There are now clear accountability and supervisory arrangements in place for trust doctors, nurses and allied health professional staff. Currently, there is effective nursing leadership on Daedalus and Sultan wards, this is less evident on Dryad ward. CHI was concerned regarding the potential for professional isolation of the staff grade doctor.

3. Systems are now in place to ensure that appropriate specialist medical and therapeutic advice is available for patients. Some good progress has been made towards multidisciplinary team working which should be developed.

4. There was a planned approach to the service development in advance of the change in use of beds in 2000. The increasing dependency of patients and resulting pressure on the service, whilst recognised by the trust, was neither monitored nor reviewed as the changes were implemented and the service developed.

5. Portsmouth Healthcare NHS Trust should be congratulated for its progress towards a culture of reflective nursing practice.

6. The trust has a strong staff focus, with some notable examples of good practice. Despite this, CHI found evidence to suggest that not all staff felt adequately supported during the police and other recent investigations.

7. Out of hours medical cover for the three wards out of hours is problematic and does not reflect current levels of patient dependency.

8. There are systems in place to support patients and relatives towards the end of the patient's life and following bereavement.

RECOMMENDATIONS

1. The Fareham and Gosport PCT should develop local guidance for GPs working as clinical assistants. This should address supervision and appraisal arrangemnts, clinical governance responsibilities and trianing needs.

2. The provision of out of hours medical cover to Daedalus, Dryad and Sultan wards should be reviewed. The deputising service and PCTs must work towards an out of hours contract which sets out a shared philosophy of care, waiting time standards, adequate payment and a disciplinary framework.

3. Fareham and Gosport PCT and East Hampshire PCT should ensure that appropriate patients are being admitted to the Gosport War Memorial Hospital with appropriate levels of support.

4. The Fareham and Gosport PCT should ensure that arrangements are in place to ensure strong, long term nursing leadership on all wards.

5. Both PCTs must find ways to continue the staff communication developments made by the Portsmouth Healthcare NHS Trust.

7 | Lessons learnt from complaints

7.1 A total of 129 complaints were made regarding the provision of elderly medicine since 1 April 1997. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra hospitals. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

7.2 Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. Three complaints in the last five months of 1998 expressed concern regarding pain management, the use of diamorphine and levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients, was considered by the police expert witnesses.

External review of complaints

7.3 One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical adviser found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 was referred to an independent review panel, which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Although the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

Complaint handling

7.4 The trust had a policy for handling patient related complaints produced in 1997 and reviewed in 2000, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure.* A leaflet for patients detailing the various stages of the complaints procedure was produced, which indicated the right to request an independent review if matters were not satisfactorily resolved together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards during CHI's visit.

7.5 Both the trust and the local community health council (CHC) described a good working relationship. The CHC regretted, however, that their resources since November 2000 had prevented them from offering the level of advice and active support to trust complainants they would have wished. The CHC did continue to support complainants who had contacted them before November 2000. New contacts were provided with a "self help" pack.

7.6 CHI found that letters to complainants in response to their complaints did not always include an explanation of the independent review stage, although this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. The 2000 update of the complaints policy stated that audit standards for complaints handling were good with at least 80% of complainants satisfied with complaint handling and 100% of complaints resolved within national performance targets. The chief executive responded to all written complaints. Staff interviewed by CHI valued the chief executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services.

7.7 Once the police became involved in the initial complaint in 1998, the trust ceased its internal investigation processes. CHI found no evidence in agendas and minutes that the trust board were formally made aware of police involvement. Senior trust managers told CHI that the trust would have commissioned a full internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not preclude full internal clinical investigation. CHI was told that neither the doctor nor portering staff involved in the care and transfer of the patient whose care was the subject of the initial police investigation were asked for statements during the initial complaint investigation.

Trust learning regarding prescribing

7.8 Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter 4). In addition, CHI learnt that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem". This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20mg to 40mg per day.

7.9 Portsmouth Healthcare NHS Trust correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mg a day. CHI understands this protocol to be the Wessex guidelines. Further correspondence in October 1999, indicated that a doctor working on the wards requested a trust policy on the prescribing of opiates in community hospitals.

7.10 A draft protocol for the prescription and administration of diamorphine by subcutaneous infusion was piloted on Dryad ward in 1999 and discussed at the trust's Medicines and Prescribing Committee in February and April 2000 following consultation with palliative care consultants. This guidance was eventually incorporated into the joint Portsmouth Healthcare NHS Trust and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain which was introduced in April 2001.

Other trust lessons

7.11 Lessons around issues other than prescribing have been learnt by the trust, though the workshop to draw together this learning was not held until early 2001 when the themes discussed were communication with relatives, staff attitudes and fluids and nutrition. Action taken by the trust since the series of complaints in 1998 are as follows:

- an increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999
- the appointment of a full time staff grade doctor in September 2000 which increased medical cover following the resignation of the clinical assistant
- piloting pain management charts and prescribing guidance approved in April 2001. Nursing documentation is currently under review, with nurse input
- one additional consultant session began in 2000, following a district wide initiative with local PCGs around intermediate care
- nursing documentation now clearly identifies prime family contacts and next of kin information to ensure appropriate communication with relatives
- all conversations with families are now documented in the medical record. CHI's review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff

7.12 Comments recorded in this workshop were echoed by staff interviewed by CHI, such as the difficultly in building a rapport with relatives when patients die a few days after transfer, the rising expectations of relatives and the lack of control Gosport War Memorial staff have over information provided to patients and relatives prior to transfer regarding longer term prognosis.

Monitoring and trend identification

7.13 A key action identified in the 2000/2001 clinical governance action plan was a strengthening of trust systems to ensure that actions following complaints were implemented. Until the dissolution of Portsmouth Healthcare NHS Trust, actions were monitored through the divisional review process, the clinical governance panel and trust board. A trust database was introduced in 1999 to record and track complaint trends. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

7.14 Portsmouth Healthcare NHS Trust offered specific training in complaints handling, customer care and loss, death and bereavement, which many staff interviewed by CHI were aware of and had attended.

KEY FINDINGS

1. The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake an 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.

2. 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.

3. Though Portsmouth Healthcare NHS Trust did begin to develop a protocol for the prescription and administration of diamorphine by syringe driver in 1999, the delay in finalising this protocol in April 2001, as part of the policy for the assessment and management of pain, was unacceptable.

4. There has been some, but not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

RECOMMENDATIONS

1. The Department of Health should work with the Association of Chief Police Officers and CHI to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible.

2. Fareham and Gosport PCT and East Hampshire PCT should ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

3. Both PCTs involved in the provision of care for older people should ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.

GMC100829-0477

8 | Clinical governance

Introduction

8.1 Clinical governance is about making sure that health services have systems in place to provide patients with high standards of care. The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

8.2 CHI has not conducted a clinical governance review of the Portsmouth Healthcare NHS Trust but has looked at how trust clinical governance systems supported the delivery of continuing and rehabilitative inpatient care for older people at the Gosport War Memorial Hospital. This chapter sets out the framework and structure adopted by the trust between 1998 and 2002 to deliver the clinical governance agenda and details those areas most relevant to the terms of reference for this investigation: risk management and the systems in place to enable staff to raise concerns.

Clinical governance structures

8.3 The trust reacted swiftly to the principles of clinical governance outlined by the Department of Health in *A First Class Service* by devising an appropriate management framework. In September 1998, a paper outlining how the trust planned to develop a system for clinical governance was shared widely across the trust and aimed to include as many staff as possible. Most staff interviewed by CHI were aware of the principles of clinical governance and were able to demonstrate how it related to them in their individual roles. Understanding of some specific aspects, particularly risk management and audit, was patchy.

8.4 The medical director took lead responsibility for clinical governance and chaired the clinical governance panel, a sub committee of the trust board. A clinical governance reference group, whose membership included representatives from each clinical service, professional group, non executive directors and the chair of the community health council, supported the clinical governance panel. Each clinical service also had its own clinical governance committee. This structure had been designed to enable each service to take clinical governance forward into whichever PCT it found itself in after April 2002. Since February 2000, the trust used the divisional review process to monitor clinical governance developments.

8.5 The service specific clinical governance committees were led by a designated clinician and included wide clinical and professional representation. Baseline assessments were carried out in each specialty and responsive action plans produced. The medical director and clinical governance manager attended divisional review meetings and reported key issues back to the clinical governance panel.

8.6 District Audit carried out an audit of the trust's clinical governance arrangements in 1998/1999. The report, dated December 1999, states that the trust had fully complied with requirements to establish a framework for clinical governance. The report also referred to the trust's document, *Improving quality – steps towards a first class service*, which was described as "of a high standard and reflected a sound understanding of clinical governance and quality assurance".

8.7 Whilst commenting favourably on the framework, the District Audit review also noted the following:

- the process for gathering user views should be more focused and the process strengthened
- the trust needed to ensure that in some areas, strategy, policy and procedure is fed back to staff and results in changed/improved practice. Published protocols were not always implemented by staff; results of clinical audit were not always implemented and reaudited; lessons learnt from complaints and incidents not always used to change practice and that research and development did not always lead to change in practice
- more work needed to be done with clinical staff on openness and the support of staff alerting senior management of poor performance

8.8 Following the review, the trust drew up a trust wide action plan (December 1999) which focused on widening the involvement and feedback from nursing, clinical and support staff regarding trust protocols and procedures, and on making greater use of research and development, clinical audit, complaints, incidents and user views to lead to changes in practice. CHI was told of a link nurse programme to take elements of this work forward.

Risk management

8.9 A trust risk management group was established in 1995 to develop and oversee the implementation of the trust's risk management strategy, to provide a forum in which risks could be evaluated and prioritised and to monitor the effectiveness of actions taken to manage risks. The group had links with other trust groups such as the clinical and service audit group, the board and the nursing clinical governance committee. Originally the finance director had joint responsibility for strategic risk with the quality manager; this was changed in the 2000/2003 strategy when the medical director became the designated lead for clinical risk. The trust achieved the clinical negligence scheme for trusts (CNST) level one in 1999. A decision was taken not to pursue the level two standard assessment due to dissolution of the trust in 2002.

8.10 The trust introduced an operational policy for recording and reviewing risk events in 1994. New reporting forms were introduced in April 2000 following a review of the assessment systems for clinical and non clinical risk. The same trust policy was used to report clinical and non clinical risks and accidents. All events were recorded in the trust's risk event database (CAREKEY). This reporting system was also used for near misses and medication errors. Nursing and support staff interviewed demonstrated a good knowledge of the risk reporting system, although CHI was less confident that medical staff regularly identified and reported risks. CHI was told that risk forms were regularly submitted by wards in the event of staff shortages. Staff shortage was not one of the trust's risk event definitions.

8.11 The clinical governance development plan for 2001/2002 stated that the focus for risk management in 2000/2001 was the safe transfer of services to successor organisations, with the active involvement of PCTs and PCGs in the trust's risk management group. Meetings were held with each successor organisation to agree future arrangements for areas such as risk event reporting, health and safety, infection control and medicines management.

Raising concerns

8.12 The trust had a whistle blowing policy dated February 2001. The Public Interest Disclosure Act became law in July 1999. The policy sets out the process staff should follow if they wished to raise a concern about the care or safety of a patient "that cannot be resolved by the appropriate procedure". NHS guidance requires systems to enable concerns to be raised outside the usual management chain. Most staff interviewed were clear about how to raise concerns within their own line management structure and were largely confident of receiving support and an appropriate response. Fewer staff were aware of the trust's whistle blowing policy.

Clinical audit

8.13 CHI was given no positive examples of changes in patient care or prescribing as a result of clinical audit outcomes. Despite a great deal of work on revising and creating policies to support good prescribing and pain management, there was no planned audit of outcome.

8.14 CHI was made aware of two trust audits of medicines since 1998. In 1999, a review of the use of neuroleptic medicines, which includes tranquillisers such as haloperidol, within all trust elderly care continuing care wards concluded that neuroleptic medicines were not being over prescribed. The same review revealed "the weekly medical review of medication was not necessarily recorded in the medical notes". The findings of this audit and the accompanying action plan, which included guidance on completing the prescription chart correctly, was circulated to all staff on Daedalus and Dryad wards. A copy was not sent to Sultan ward. There was a reaudit in late 2001 which concluded that overall use of neuroleptic medicines in continuing care wards remained appropriate.

8.15 More recently, the Fareham and Gosport PCT has undertaken a basic audit based on the prescription sheets and medical records of patients cared for on Sultan, Dryad and Daedalus wards during two weeks in June 2002. The trust concluded "that the current prescriping of opiates, major tranquilisers and hyocine was within British National Formulary guidelines." No patients were prescribed midazolam during the audit timeframe.

KEY FINDINGS

1. The trust responded proactively to the clinical governance agenda and had a robust framework in place with strong corporate leadership.

2. Although a system was in place to record risk events, understanding of clinical risk was not universal. The trust had a whistle blowing policy, but not all staff were aware of it. The policy did not make it sufficiently clear that staff could raise concerns outside of the usual management channels if they wished.

RECOMMENDATIONS

1. The Fareham and Gosport PCT and East Hampshire PCT must fully embrace the clinical governance developments made and direction set by the trust.

2. All staff must be made aware that the completion of risk and incident reports is a requirement for all staff. Training must be put in place to reinforce the need for rigorous risk management.

3. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

4. The Fareham and Gosport PCT and East Hampshire PCT should consider a revision of their whistle blowing policies to make it clear that concerns may be raised outside of normal management channels.

APPENDIX A

Documents reviewed by CHI and/or referred to in the report

A) NATIONAL DOCUMENTS

1. Modern Standards and Service Models, Older People, National Service Framework for Older People, Department of Health, March 2001
2. 'Measuring disability a critical analysis of the Barthel Index', British Journal of Therapy and Rehabilitation, April 2000, Vol 7, No 4
3. The Public Interest Disclosure Act 1998 – whistleblowing in the NHS, NHS Executive, August 1999
4. Guidelines for the administration of medicines, (including press statement) United Kingdom Central Council for Nursing, Midwifery and Health Visiting, October 2000
5. Extension of independent nursing prescribing, items prescribable by nurses under the extended scheme, Department of Health, February 2002
6. Essence of Care: patient-focused benchmarking for healthcare practitioners, Department of Health, February 2001
7. Caring for older people: A nursing priority, integrated knowledge, practice and values, The nursing and midwifery advisory committee, March 2001
8. British National Formulary 41, British Medical Association, Royal Pharmaceutical Society of Great Britiain, 2001
9. Consent – What you have a right to expect: a guide for relatives and carers, Department of Health, July 2001
10. Making a Difference, strengthening the nursing, midwifery and health visiting contribution to health and healthcare, Summary, The Department for Health, July 1999
11. Improving Working Lives Standard, NHS employers commited to improving the working lives of people who work in the NHS, Department of Health, September 2000
12. The NHS plan, a plan for investment, a plan for reform, Chapter 15, dignity, security and independence in old age, The Department of Health, July 2000
13. Standards for health and social care services for older people, The Health Advisory Service 2000, May 2000
14. Reforming the NHS Complaints Procedure: a listening document, The Department of Health, September 2001

B) DOCUMENTS RELATING TO PORTSMOUTH HEALTHCARE NHS TRUST

1. Our work, our values – a guide to Portsmouth Healthcare NHS Trust, Portsmouth Healthcare NHS Trust, undated
2. Annual reports, Portsmouth Healthcare NHS Trust, 2000-2001, 2000, 1998-1999
3. Local health, local decisions – proposals for the transfer of management responsibility for local health services in Portsmouth and south east Hampshire from Portsmouth

GMC100829-0482

Healthcare NHS Trust to local Primary Care Trusts and West Hampshire NHS Trust, South East regional office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Hampshire Health Authority, September 2001

4. Dissolution project proposal, Portsmouth Healthcare Trust, undated

5. Trust dissolution: summary of meeting to agree the future management arrangements for risk and clinical governance systems and groups, Portsmouth Healthcare NHS Trust, 1 November 2001

6. Looking forward... the next five years 1995-2000, Portsmouth Healthcare NHS Trust, September 1994

7. Business plans 2000-2001, 1999-2000, 1998-1999, 1997-1998, Portsmouth Healthcare NHS Trust

8. Health improvement programme 2000-2003, Portsmouth and south east Hampshire, Isle of Wight, Portsmouth and South East Hampshire, April 2000

9. Fareham health improvement programme 2000-2002, Fareham and Gosport Primary Care Groups, undated

10. A report on a future Patient Advice Liaison Service for Fareham & Gosport Primary Care Trust, Portsmouth Healthcare NHS Trust, November 2001

11. Gosport War Memorial Patient Survey results, Portsmouth Healthcare NHS Trust, November 2001, October 2001, July 2001.

12. 2001/2002 Services and Financial Framework (SAFF) cost and service pressures, Portsmouth Healthcare NHS Trust, undated

13. Gosport War Memorial Hospital outpatient clinics rota, 9 July 2001

14. User involvement in service development: A framework, Portsmouth Healthcare NHS Trust, undated

15. Isle of Wight, Portsmouth & South East Hampshire Health Authority joint investment plan for older people 2001-2002, Isle of Wight, Portsmouth & South East Hampshire Health Authority, undated

16. Portsmouth Healthcare NHS Trust, trust board agendas and strategic briefing documents:

    Trust board strategic briefing 18 October 2001, 19 July 2001, 21 June 2001,18 January 2001, 19 October 2000, 20 July 2000, 15 June 2000, 20 April 2000, 20 January 2000, 21 October 1999, 15 July 1999, 17 June 1999, 15 April 1999, 21 January 1999, 22 October 1998, 24 September 1998

    Public meeting of the trust board 20 September 2001, 17 May 2001,15 February 2001, 16 November 2000, 21 September 2000, 18 May 2000, 17 February 2000, 18 November 1999, 16 September 1999, 20 May 1999, 18 February 1999, 19 November 1998

    Agenda for part two of meeting of trust board 20 September 2001, 17 May 2001, 15 February 2001, 16 November 2000, 21 September 2000, 18 May 2000, 17 February 2000, 18 November 1999, 16 September 1999, 20 May 1999, 18 February 1999, 19 November 1998, 24 September 1998

17. Divisional review 2000 Gosport and Fareham division, Portsmouth Healthcare NHS Trust, 8 February 2000, 10 August 2000, 16 May 2000, 11 November 1999

18. National service framework: older people steering group (district wide implementation team) documents, Isle of Wight, Portsmouth and South East Hampshire health authority, undated

19. Correspondence: re Healthcall data 2001 analysis, Knapman practice, 22 June 2002

20. Correspondence: re Healthcall regarding contract for 2002, Healthcall business manager, March 2002
21. Patient environment assessment and action plan, Portsmouth Healthcare NHS Trust, August and September 2000
22. Combined five year capital programme 2001/2002-2005/2006, Portsmouth Healthcare NHS Trust, Portsmouth City Primary Care Trust, East Hampshire NHS Primary Care Trust, 8 November 2001
23. Portsmouth Healthcare NHS Trust: Investors in People report, Western Training and Enterprise Council, July 1999
24. Portsmouth Healthcare NHS Trust, Quality report – governance indicators, quarter ending 30 June 2001, 31 March 2001, 31 December 2000, 30 September 2000, 30 June 2000, 31 March 2000, 31 December 1999, 30 September 1999, 30 June 1999, 31 March 1999, 31 December 1998, 30 September 1998, 30 June 1998, 31 March 1998, 31 December 1997, 30 September 1997, 30 June 1997
25. Annual quality report to Portsmouth and South East Hampshire Health Authority (quarter 3 2000/2001), Portsmouth Healthcare NHS Trust, 27 February 2001
26. Improving quality – steps towards a First class service, Portsmouth Healthcare NHS Trust September 1998
27. Infection control services, Portsmouth Hospitals NHS Trust and Portsmouth Healthcare NHS Trust, Nursing practice audit, Portsmouth Healthcare NHS Trust, 9 May 2001
28. Emergency incidents originating at Gosport War Memorial Hospital, Hampshire Ambulance Service NHS Trust, April 2000-February 2002
29. Staff handbook, Portsmouth Healthcare NHS Trust, undated
30. Junior doctors' accreditation information, pack supplied by Portsmouth Healthcare NHS Trust, undated
31. GP contracts for trust working, Portsmouth Healthcare NHS Trust, December 1979-May 2001
32. GP contracts for trust working, Out of hours GP contract, Portsmouth Healthcare NHS Trust, April 1999-March 2000, June 2001-March 2002
33. Strategy for employing locum medical staff, Portsmouth Healthcare NHS Trust, undated
34. The development of clinical supervision for nurses, nurse consultant, adult mental health services, Portsmouth Healthcare NHS Trust undated
35. Correspondence/memorandum re: staff opinion survey results, Portsmouth Healthcare NHS Trust, 18 December 2001
36. Staff opinion survey 2000, Portsmouth Healthcare NHS Trust undated
37. Common actions arising from staff opinion survey results, personnel department, 19 October 2001
38. Memorandum re: senior managers on call, Portsmouth Healthcare NHS Trust, 29 September 2000
39. Personnel and human resources/management strategy and action plan, Portsmouth Healthcare NHS Trust, personnel director, October 2001
40. Strategy for human resource management and important human resource issues, Portsmouth Healthcare NHS Trust, personnel director, October 1996

41. Human resource management, Portsmouth and South East Hampshire Health Authority Community Health Care Services, November 1991
42. Audit of standards of oral hygiene within the stroke service, Portsmouth Healthcare NHS Trust November 1999-April 2000
43. Clinical Stroke service guidelines, Department of medicine for elderly people, undated
44. Reaudit evaluation of compliance with revised handling assessment guidelines, Portsmouth Healthcare NHS Trust, June 1998-November 1998
45. Feeding people, trust wide reaudit of nutritional standards, Portsmouth Healthcare NHS Trust, November 2001
46. Trust records strategy, records project manager, Portsmouth Healthcare NHS Trust March 2001
47. A guide to medical records, a pocket guide to all medical staff, Portsmouth Healthcare NHS Trust, June 2000
48. Health records all specialities core standards and procedures, Portsmouth Healthcare NHS Trust (incorporating East Hants Primary Care Trust and Portsmouth City Primary Care Trust), December 1998 updated February 2000 and May 2001
49. Referral to old age psychiatry form, Portsmouth Healthcare NHS Trust, undated
50. Patients affairs procedure – death certification and post mortems, department of medicine for elderly people, Queen Alexandra Hospital, (undated)
51. Audit of compliance with bed rails guidelines in community hospitals, Portsmouth Healthcare NHS Trust, August 2001
52. Patient flows, organisational chart, 24 October 2001
53. Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts Joint Generic Transfer Document: Protocol for the transfer to GP step down beds, Portsmouth Hospitals and Portsmouth Healthcare NHS Trusts, November 2000
54. Discharge summary form, guidance notes for completion, Portsmouth Healthcare NHS Trust, 21 November 2001
55. Audit of patient records, December 1997-July 1998, Portsmouth Healthcare NHS Trust
56. Audit of nutritional standards, October 1997-April 1998, Portsmouth Healthcare NHS Trust, undated
57. Falls policy development - strategy to reduce the number of falls in community hospitals, Portsmouth Healthcare NHS Trust, undated
58. Minutes of falls meetings held on 26 July 2001,13 June 2001, 26 February 2001, 18 January 2001, 23 November 2000, 5 October 2000, Portsmouth Healthcare NHS Trust
59. Stepping stones: how the need for stepping stones came about, Portsmouth Healthcare NHS Trust, undated
60. Portsmouth Healthcare NHS Trust Policies: Resuscitation status policy, April 2000; Whistleblowing policy, February 2001; Risk management policy, January 2001; Recording and reviewing risk events policy, May 2001; Control and administration of medicines by nursing staff policy, January 1997; Prescription writing policy, July 2000; Policy for assessment and management of pain, May 2001; Training and education policy, April 2001; Bleep holder policy review, 15 May 2001; Prevention and management of pressure ulcers policy, May 2001; Prevention and management of malnutrition within trust residential and hospital services, November 2000; Client records and record keeping policy, December 2000; Trust corporate policies, guidance for staff, revised August 2000;

Psychiatric involvement policy, November 2001; Induction training policy, October 1999 Handling patient related complaints policy, Portsmouth Healthcare NHS Trust, January 2000; Domestic abuse in the workplace policy, July 2000

61. Medicines policy incorporating the IV policy, final draft – version 3.5, Portsmouth Hospitals NHS Trust, Royal Hospital Haslar, Portsmouth Healthcare NHS Trust, August 2001

62. Non emergency patient transport request form, Portsmouth Hospitals and Healthcare NHS Trust, undated

63. Patient transport – standards of service, Portsmouth Healthcare NHS Trust, Development Directorate, March 2001

64. Booking criteria and standards of service – criteria for use of non emergency patient transport, Portsmouth Hospitals and Healthcare NHS Trust and Hampshire Ambulance Trust, undated

65. Prescribing formulary, Portsmouth District October 2001, Portsmouth Hospitals NHS Trust, Portsmouth Healthcare NHS Trust, General Medical Practitioners, Portsmouth and South East Hampshire Health Authorities and Royal Hospital Haslar (not complete)

66. Wessex palliative care handbook: guidelines on clinical management, fourth edition, Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, The Rowans (Portsmouth Area Hospice), undated

67. National sentinel clinical audit, evidence based prescribing for older people: Report of national and local results, Portsmouth Healthcare NHS Trust, undated

68. Compendium of drug therapy guidelines 1998 (for adult patients only), Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, 1998

69. Draft protocol for prescription and administration of diamorphine by subcutaneous infusion, medical director, Portsmouth Healthcare NHS Trust, 15 December 1999

70. Medicines and prescribing committee meeting: agendas 3 February 2000, 4 May 2001, 6 April 2000, 6 July 2000, 3 November 2000

71. Medicines and prescribing committee meeting: minutes 3 November 2000, 5 January 2001

72. Correspondence: protocol for prescription administration of diamorphine by subcutaneous infusion, Portsmouth Healthcare NHS Trust, 7 February 2000, 11 February 2000

73. Correspondence: Portsmouth Healthcare NHS Trust syringe driver control, Portsmouth Healthcare NHS Trust, 21 February 2000

74. Correspondence: diamorphine guidelines, Portsmouth Healthcare NHS Trust, 21 February 2000

75. Audit of prescribing charts: questionnaire Portsmouth Healthcare NHS Trust, undated

76. Administration of controlled drugs – the checking role for support workers: guidance note for ward/clinical managers, Portsmouth Healthcare NHS Trust, February 1997

77. Scoresheet – medicines management standard 2001/2002, Portsmouth Healthcare NHS Trust, undated

78. Organisational controls standards, action plan 2000/2001, Portsmouth Healthcare NHS Trust, November 2001

79. Diagram of Medicines Management Structure, Portsmouth Healthcare NHS Trust, 16 October 2000

80. Summary medicines use 1997/1998 to 2000/2001 for wards Dryad, Daedalus and Sultan, Portsmouth Hospitals NHS Trust pharmacy service, April 2002

81. Training on demand: working in partnership, Portsmouth Healthcare NHS Trust, undated
82. Programme of training events 2001-2002, Portsmouth Healthcare NHS Trust, undated
83. Sultan ward leaflet, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust
84. Post mortem information for relatives and hospital post mortem consent form, Portsmouth Healthcare NHS Trust, January 2000
85. Proposal for Portsmouth Healthcare NHS Trust: the provision of an employee assistance programme for Portsmouth Healthcare NHS Trust, Corecare, 16 March 2000
86. Gosport War Memorial Hospital chaplains' leaflet, Portsmouth Healthcare NHS Trust, undated
87. Gosport War Memorial Hospital, chaplains and Portsmouth Healthcare NHS Trust: because we care, community health services – leaflets, Portsmouth Healthcare NHS Trust, undated
88. Talking with dying patients, loss death and bereavement, staff handout, no author, undated
89. Multidisciplinary post registration development programme, 2001
90. Gerontological nursing programme: proposal for an integrated work based learning and practice development project between the RCN's gerontological nursing programme, Portsmouth Health Care NHS Trust, PCTs and Portsmouth University: COMMUNITY HOSPITALS, Royal College of Nursing, version 2.0 2001
91. Multidisciplinary post registration year 2000-2001: lecture programme, Portsmouth Healthcare NHS Trust, November 2001
92. Training programme 2002 and in service training: list of lectures, Portsmouth Healthcare NHS Trust, undated
93. Occupational therapy service – supervision manual, Portsmouth Healthcare NHS Trust, Portsmouth City Council, Hampshire County Council Social Service department, undated
94. Acute life threatening events recognition and treatment (ALERT): A multiprofessional University of Portsmouth course in care of the acutely ill patient, October 2000
95. Training and development for nursing staff in Portsmouth Healthcare NHS Trust community hospitals relating to intermediate care: Progress report, Portsmouth Healthcare NHS Trust, 12 February 2001
96. E-learning at St James's: catalogue of interactive training programmes, November 2001
97. Valuing diversity pamphlet: diversity matters, Portsmouth Healthcare NHS Trust, undated
98. Procedural statement – individual performance review: recommended documentation and guidance notes, personnel director, Portsmouth Healthcare NHS Trust, April 2001
99. IPR audit results 2000, community hospitals service lead group, 22 March 2001
100. Clinical nursing development, promoting the best practice in Portsmouth Healthcare, Portsmouth Healthcare NHS Trust, January 1998
101. An evaluation of clinical supervision activity in nursing throughout Portsmouth Healthcare NHS Trust, Portsmouth Healthcare NHS Trust, December 1999
102. Your views matter: making comments or complaints about our services, Portsmouth Healthcare NHS Trust, undated

103. Anonymised correspondence on complaints relating to Gosport War Memorial Hospital since 1998

104. Learning from experience: action from complaints and patient based incidents, 1998-2001, Portsmouth Healthcare NHS Trust

105. Handling complaints course facilitators notes, Portsmouth Healthcare NHS Trust, 21 May 1999

106. Community hospitals governance framework, January 2001

107. Community hospitals and Portsmouth Healthcare NHS Trust clinical governance development plan, 2001- 2002

108. General rehabilitation clinical governance group, minutes of meeting 6 September 2001

109. Stroke service clinical governance meeting, minutes of meeting 12 October 2001

110. Continuing care clinical governance group, minutes of meeting 7 November 2001, Portsmouth Healthcare NHS Trust

111. Community hospitals clinical leadership programme update, Portsmouth Healthcare NHS Trust, 19 November 2001

112. Practice development programme: community hospitals clinical governance, Portsmouth Healthcare NHS Trust, March 1999

113. Third quarter quality/clinical governance report, community hospitals service lead group, Portsmouth Healthcare NHS Trust, January 2000

114. Community hospitals clinical governance baseline assessment action plan, September 1999

115. Clinical governance: minimum expectations of NHS trusts and primary care trusts from April 2000. Action plan - review March 2001, Portsmouth Healthcare NHS Trust, undated

116. Clinical governance annual report 2000/2001 and 1999/2000, Portsmouth Healthcare NHS Trust

117. Risk event forms and instructions, Portsmouth Healthcare NHS Trust, undated

118. Clinical governance baseline assessment trust wide report, 1999, Portsmouth Healthcare NHS Trust, undated

119. Trust clinical governance panel meeting minutes on 16 May 2001, Portsmouth Healthcare NHS Trust

120. Memorandum re: implementation of clinical governance, Portsmouth Healthcare NHS Trust, 11 June 1999

121. Risk management strategy 2000/2003, 1999/2002 and 1998/2001, Portsmouth Healthcare NHS Trust

122. Gosport War Memorial Hospital patient survey action plan, Portsmouth Healthcare NHS Trust, (undated)

C) DOCUMENTS RELATING TO THE DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE AT THE GOSPORT WAR MEMORIAL HOSPITAL

1. Dryad ward away day notes, Gosport War Memorial Hospital, 22 January 2001, 18 May 1998
2. Community hospital service plan 2001/2002, Portsmouth Healthcare NHS Trust, undated
3. Community hospitals GP bed service plan 2000/2001, Portsmouth Healthcare NHS Trust, 30 November 1999
4. Intermediate care and rehabilitation services proposal, Fareham and Gosport primary care groups, May 2000.
5. Team objectives 1999/2000 - Sultan ward, Portsmouth Healthcare NHS Trust, 21 November 2001
6. Gosport War Memorial Hospital key objectives 2000/2001, 1998/1999, 1997/1998 and 1996/1997, Portsmouth Healthcare NHS Trust
7. Gosport War Memorial Hospital leaflet and general information, Portsmouth Healthcare NHS Trust, undated
8. Gosport health improvement programme (HIMP) 2000-2002, Fareham and Gosport primary care groups, undated
9. Fareham and Gosport primary care groups intermediate care and rehabilitation services, Fareham and Gosport primary care groups, undated
10. Patient throughput data from Sultan, Dryad and Daedalus wards 1997/1998 - 2000/2001, Fareham and Gosport primary care groups, April 2002
11. Fareham and Gosport staff management structure, community hospitals, Portsmouth Healthcare NHS Trust, 25 October 2001
13. Fareham and Gosport locality division structure diagram, Portsmouth Healthcare NHS Trust, 25 October 2001
14. Fareham and Gosport older persons' locality implementation group progress report. Isle of Wight, Portsmouth and South East Hants Health Authority, Fareham and Gosport primary care groups, undated
15. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
16. Correspondence from department of medicine for elderly people re: national sentinel audit of stroke 1999, Portsmouth Healthcare NHS Trust, 8 March 2000
17. Job description: Lead consultant department of medicine for elderly people (draft 4), Portsmouth Healthcare NHS Trust, February 1999
18. Job description: clinical assistant position to the geriatric division in Gosport, Portsmouth and South East Hampshire Health Authority, April 1988
19. Job description: service manager (H Grade) department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 29 August 2000
20. Job description: Service manager, community hospitals Fareham and Gosport, Portsmouth Healthcare NHS Trust, February 2000
21. University of Portsmouth, Clinical nursing governance in a department of elderly medicine: an exploration of key issues and proposals for future development, Portsmouth Healthcare NHS Trust and Portsmouth University, May 2000

22. One year on: aspects of clinical nursing governance in the department of elderly medicine, Portsmouth Healthcare NHS Trust, September 2001
23. Operational policy, bank/overtime/agency, Fareham and Gosport community hospitals and elderly mental health, Portsmouth Healthcare NHS Trust, 1 May 2001
24. Job description: full time staff grade physician, Gosport War Memorial Hospital department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 5 July 2000
25. Correspondence re: staff grade physician contract – Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 26 September 2001
26. Correspondence re: consultant in medicine for the elderly contract, Wessex Regional Health Authority, 28 January 1992
27. Essential information for medical staff department of medicine for elderly people, Portsmouth Healthcare NHS Trust, undated
28. Department of medicine for elderly people, consultant timetables August 1997-November 2001, Portsmouth Healthcare NHS Trust
29. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
30. Information for supervision arrangements for Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, November 2001
31. Clinical managers meeting minutes, Portsmouth Healthcare NHS Trust, 12 November 2001
32. Notes of action learning meeting, Portsmouth Healthcare NHS Trust, 11 June 2001
33. Notes from team leader meetings for the Daedalus ward, Portsmouth Healthcare NHS Trust, 5 April 2001
34. Notes of Daedalus ward meeting, Portsmouth Healthcare NHS Trust, 6 August 2001
35. Fareham & Gosport locality division, nursing accountability pathway, Portsmouth Healthcare NHS Trust, 25 October 2001
36. Medical accountability structure for Gosport War Memorial Hospital, undated
37. Supervision arrangement consultant timetable at Gosport War Memorial Hospital 1998-2001, Portsmouth Healthcare NHS Trust
38. Night skill mix review Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 28 March 2001
39. Vacancy levels 1998-2001 for Sultan, Daedalus and Dryad, Portsmouth Healthcare NHS Trust, 21 November 2001
40. Sickness absence statistics for Daedalus Ward, Gosport War Memorial Hospital, 2000-2001, undated
41. Sickness absence statistics for Sultan Ward, Gosport War Memorial Hospital, 1998-2001, undated
42. Wastage for qualified nurses – Daedalus, Dryad and Sultan Ward, undated
43. Winter escalation plans elderly medicine and community hospitals, Portsmouth Healthcare NHS Trust, undated
44. Audit of detection of depression in elderly rehabilitation patients, January-November 1998, Portsmouth Healthcare NHS Trust, undated

45. District audit review of rehabilitation service for older people 2000/2001, Portsmouth Healthcare NHS Trust, January 2001

46. Memorandum to all medical staff re: rapid tranquillisation and attached protocol – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 23 February 2001

47. Correspondence re: guidelines on management of acute confusion from general manager – department of medicine for elderly people, Portsmouth Healthcare NHS Trust, 18 October 2001

48. Memorandum to all consultants from consultant geriatrician re: management of acute confusion elderly medicine, Queen Alexandra Hospital Portsmouth Healthcare NHS Trust, 30 April 2001

49. Community hospitals: guidelines for confirmation of death, Portsmouth Healthcare NHS Trust, policy date May 1998, review date May 1999

50. Memorandum: Guidelines for admission to Daedalus and Dryad ward, Portsmouth Healthcare NHS Trust, 4 October 2000

51. Clinical policy, admission and discharge policy, Portsmouth Healthcare NHS Trust, September 2000

52. Urgent notice for all medical and nursing staff in the event of a suspected fracture and/or dislocation of a patient on the above ward, Daedalus and Dryad wards, Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 16 November 2001

53. Procedure for the initial management of medical emergencies in Gosport War Memorial Hospital, Portsmouth Healthcare NHS Trust, 15 January 2001

54. Audit of neuroleptic prescribing in elderly medicine, Portsmouth Healthcare NHS Trust, January-November 1999, November 1998-July 1999, September-December 2001

55. Administration of medicines, community hospitals – programme for updating qualified staff, Portsmouth Healthcare NHS Trust, 13 March 1997

56. Memorandum re: seminar – osteoporosis and falls, 14 November 2001, clinical assistant teaching elderly medicine, Portsmouth Healthcare NHS Trust, 19 October 2001

57. Introduction to Gosport War Memorial Hospital for staff, Portsmouth Healthcare NHS Trust, undated

58. Competence record and development for qualified nurses 1998-2001, Sultan, Dryad and Daedalus wards

59. Fareham and Gosport induction programme, 9 November 2001, Portsmouth Healthcare NHS Trust, undated

60. Training and development in community hospitals workshops – practice development facilitators (Gosport War Memorial Hospital, St Christophers Hospital, Emsworth Victoria Cottage Hospital, Petersfield Community Hospital, Havant War Memorial Hospital), East Hampshire Primary Care Trust, undated

61. Occupational therapy service – continuous professional development and training, Fareham and Gosport locality, occupational therapy professional advisor, 23 November 2001

62. Analysis of complaints at Gosport War Memorial Hospital, workshop notes and action plans, February 2001

63. Fareham and Gosport Primary Care Groups: Proposal to establish a primary care trust for Fareham and Gosport, Isle of Wight, Portsmouth and South East Hampshire Health Authority, July 2001

64. March 2001 Final monitoring report intermediate care, Portsmouth Healthcare NHS Trust, May 2001

D) DOCUMENTS RELATING TO HAMPSHIRE CONSTABULARY INVESTIGATIONS

1. Police expert witness report, Professor B Livesley, MD, FRCP, 9 November 2000
2. Police expert witness report, Professor G Ford, MA, FRCP, 12 December 2001
3. Police expert witness report, Dr K Mundy, FRCP, 18 October 2001

E) OTHER DOCUMENTS RELATING TO GOSPORT WAR MEMORIAL HOSPITAL

1. A local procedure for the identification and support of primary care medical practitioners whose performance is giving cause for concern, Isle of Wight, Portsmouth and South East Hampshire Health Authority and local medical committee, undated
2. Clinical governance and clinical quality assurance, the baseline assessment framework, NHS Executive south east region, 1999
3. Clinical Governance, Audit 1998/1999 & Summary report, District Audit, December 1999

GMC100829-0492

APPENDIX B

Views from patients and relatives/friends

METHODS OF OBTAINING VIEWS

i. The investigation sought to establish the views of people who had experience of services for older people at the Gosport War Memorial Hospital since 1998.

ii. CHI sought to obtain views about the service through a range of methods. People were invited to:

- meet with members of the investigation team
- fill in a short questionnaire
- write to the investigation team
- contact by telephone or email

iii. In November 2001, information was distributed about the CHI investigation at Gosport War Memorial Hospital to stakeholders, voluntary organisations and statutory stakeholders. This information included posters advertising stakeholder events, information leaflets about the investigation, questionnaires and general CHI information leaflets. Press releases were issued in local newspapers and radio stations. The Hampshire Constabulary agreed to forward CHI contact details to families who had previously expressed their concerns to them.

iv. The written information was distributed to a large group of potential stakeholders. In total 36 stakeholders and 59 voluntary organisations will have received the above information. These people included:

- Motor Neurone Disease Association, Alzheimer's Society, League of Friends and other community groups such as the Gosport Stroke Club and Age Concern
- Portsmouth and South East Hampshire Community Health Council, Isle of Wight, Portsmouth and South East Hampshire Health Authority, local medical committee, members of parliament, nursing homes, Portsmouth social services and Fareham and Gosport primary care groups

STAKEHOLDER RESPONSES

i. CHI received the following responses from patients, relatives, carers, friends and voluntary organisations.

Letters	Questionnaires	Telephone interviews	*Stakeholder interviews
7	2	10	17

(*stakeholders were counted according to the number of attendees and not based on number of interviews)

ii. A number of people who contacted CHI did so using more than one method. In these cases any other form of submitted evidence, was incorporated as part of the stakeholders contact.

Figure B.1 Concerns about care raised by stakeholders by ward and date

	Dryad	Daedalus	Sultan	GWMH	TOTAL
1998		8		2	10
1999	1	5			6
2000		3	3	1	7
2001		1		1	2
GWMH				2	2
TOTAL	1	17	3	6	27

GWMH – Gosport War Memorial Hospital

ANALYSIS OF VIEWS RECEIVED

i. During the CHI investigation stakeholder views highlighted both positive and less positive experiences of patient care.

Positive experiences

ii. CHI received nine letters from stakeholders commenting on the satisfaction of the care that the patients received and highlighting the excellent level of care and kindness demonstrated by the staff. This was also supported by 400 letters of thanks and donations received by the Gosport War Memorial Hospital. The most frequently recurring positive comments from stakeholders were about staff attitude (five responses) and the environment (five responses). Other positive feedback was received about access to services, transfer, prescribing, end of life arrangements, communication and complaints.

iii. The overall analysis of the stakeholder comments indicated that staff attitude and the environment were most highly commended. Examples of staff attitude included comments such as, "one lovely nurse on Dryad went to say hello to every patient even before she got her coat off" and "as a whole the ward was lovely and there was no complaints against the staff". The environment was described as being tidy and clean with good decor. Another comment recognised the ward's attention to maintaining patient dignity with curtains been drawn reducing attention to the patient. One stakeholder commented on the positive experience they had when dealing with the trust concerning a complaint they had made.

Less positive experiences

iv. A number of less positive experiences of patients/friends and relatives were shared with CHI by stakeholders. The following table outlines the most frequently recurring negative comments that corresponded with CHI's terms of reference.

Figure B.2 Less positive views of patient and relative/friend experiences

View	Frequency of responses
Communication with relatives/carers/friends	14
Patient transfer	10
Nutrition and fluids	11
Prescription of medicines	9
Continence management, catheritisation	8
Staff attitude	8
End of life communication with:	
patients	4
relatives/carers/friends	6
Humanity of care ie access to buzzer, clothing	8

v. Patient transfer. Contacts commented on the state of the patient's health before and during the transfer. Other stakeholders mentioned the time that it took to transfer the patient and also highlighted the inappropriate method of transporting the patient.

vi. Nutrition and fluids. Stakeholders highlighted a lack of help in feeding patients. They commented on how dehydrated the patients appeared and the lack of positive communication between the relative/carer and the staff to overcome the relative/carer's concern about the level of nutrition and fluids.

vii. Humanity of care.

- incontinence management – stakeholders felt that there was limited help with patients that needed to use the toilet
- attitude of staff – stakeholders commented on staff attitude, mentioning the length of time it took for staff to respond. Other comments related to the basic lack of care for patients in their last few days
- provision of bells – stakeholders observed that the bells were often out of the patients reach
- management of clothing – stakeholders commented that the patients were never in their own clothes

viii. Arrangements for the prescription, administration, review and recording of medicines. The majority of concerns were around the prescribing of diamorphine. Others centred on those authorised to prescribe the medication to the patient and how this was communicated to the relatives/carer.

ix. Communication and collaboration between the trust and patients, their relatives and carers and with partner organisations. Interviewees indicated a lack of staff contact with the relatives/carers about the condition of the patient and the patient's care plan. Other interviewees commented on how some of the staff were not approachable. One interviewee referred to the absence of lay terms to describe a patient's condition, making it difficult to understand the patient's status of health.

x. Arrangements to support patients and their relatives and carers towards the end of the patient's life. Stakeholders mainly thought that there was a lack of communication from the staff after their relative had died.

xi. Three of the contacts had made complaints to the trust through the NHS complaints procedure. All were dissatisfied about the trust response.

APPENDIX C

Portsmouth Healthcare NHS Trust staff and non executive directors interviewed by CHI

- Baldacchino, L, Health Care Support Worker
- Banks, Dr V, Lead Consultant
- Barker, D, Staff Nurse
- Barker, M, Enrolled Nurse
- Barrett, L, Staff Nurse
- Beed, P, Clinical Manager
- Brind, S, Occupational Therapist
- Cameron, F, General Manager
- Carroll, P, Occupational Therapist
- Clasby, J, Senior Nurse
- Crane, R, Senior Dietician
- Day, G, Senior Staff Nurse
- Douglas, T, Staff Nurse
- Dunleavy, J, Staff Nurse
- Dunleavy, S, Physiotherapist
- Goode, P, Health Care Support Worker
- Hair, Revd J, Chaplain
- Hallman, S, Senior Staff Nurse (until 11 September 2000)
- Hamblin, G, Senior Staff Nurse
- Haste, A, Clinical Manager
- Hooper, B, Project Director
- Humphrey, L, Quality Manager
- Hunt, D, Staff Nurse (until 6 January 2002)
- Jarrett, Dr D, Lead Consultant
- Joice, C, Staff Nurse (until 4 October 1999)
- Jones, J, Corporate Risk Advisor
- Jones, T, Ward Clerk
- King, P, Personnel Director
- King, S, Clinical Risk Advisor
- Landy, S, Senior Staff Nurse
- Langdale, H, Health Care Support Worker
- Law, D, Patient Affairs Manager

- Lee, D, Complaints Convenor & Non Executive Director
- Lock, J, Sister (retired 1999)
- Loney, M, Porter
- Lord, Dr A, Lead Consultant
- Mann, K, Senior Staff Nurse
- Melrose, B, Project Manager – Complaints
- Millett, M, Chief Executive (until 31 March 2002)
- Monk, A, Chairman
- Nelson, S, Staff Nurse
- Neville, J, Staff Nurse (until 1 January 2001)
- O'Dell, J, Practice Development Facilitator
- Parvin, J, Senior Personnel Manager
- Peach, J, Service Manager
- Peagram, L, Physiotherapy Assistant
- Pease, Y, Staff Nurse
- Phillips, C, Speech & Language Therapist
- Piper, I, Operational Director
- Qureshi, Dr L, Consultant
- Ravindrance, Dr A, Consultant
- Reid, Dr I, Medical Director
- Robinson, B, Deputy General Manager
- Scammel, T, Senior Nurse Coordinator
- Taylor, J, Senior Nurse
- Thomas, Dr E, Nursing Director
- Thorpe, M, Health Care Support Worker
- Tubbitt, A, Senior Staff Nurse
- Walker, F, Senior Staff Nurse
- Wells, P, District Nurse
- Wigfall, M, Enrolled Nurse
- Wilkins, P, Senior Staff Nurse
- Williams, J, Nurse Consultant
- Wilson, A, Senior Staff Nurse
- Wood, A, Finance Director
- Woods, L, Staff Nurse
- Yikona, Dr J, Staff Grade Physician

CHI is grateful to Caroline Harrington for scheduling interviews.

APPENDIX D

Meetings or telephone interviews with external agencies with an involvement in elderly care at Gosport War Memorial Hospital

- Portsmouth Hospitals NHS Trust

  Jill Angus, Clinical Discharge Coordinator

  Wendy Peckham, Discharge Planner for Medicine

  Clare Bownass, Ward Sister

  Sonia Baryschpolec, Staff Nurse

  Sam Page, Bed Manager, Royal Haslar Hospital

  Sally Clark, Patient Transport Manager

  Julie Sprack, Senior Nurse

  Jeff Watling, Chief Pharmacist

  Vanessa Lawrence, Pharmacist

- Hampshire Ambulance Service NHS Trust

  Alan Lyford, Patient Transport Service Manager

- Isle of Wight, Portsmouth & South East Hampshire Health Authority

  Penny Humphris, Chief Executive

  Dr Peter Old, Director of Public Health

  Nicky Pendleton, Progamme Lead for Elderly Care Services

- NHS Executive south east regional office

  Dr Mike Gill, Regional Director of Public Health

  Dr David Percy, Director of Education and Training

  Harriet Boereboom, Performance Manager

- Portsmouth and South East Hampshire Community Health Council

  Joyce Knight, Chairman

  Christine Wilkes, Vice Chair

  Margaret Lovell, Chief Officer

- Hampshire Constabulary

  Detective Superintendent John James

GMC100829-0498

- Portsmouth Social Services

  Sarah Mitchell, Assistant Director (Older People)

  Helen Loten, Commissioning and Development Manager

- Hampshire Social Services

  Tony Warns, Service Manager for Adults

- Alverstoke House Nursing and Residential Care Home

  Sister Rose Cook, Manager

- Glen Heathers Nursing and Residential Care Home

  John Perkins, Manager

Other

- League of Friends

  Mary Tyrell, Chair

  Geoff Rushton, Former Treasurer

- Motor Neurone Disease Association

  Mrs Fitzpatrick

- Members of Parliament

  Peter Viggers, MP for Gosport

  Sydney Rapson, MP for Portsmouth North

- Primary Care Groups

  John Kirtley, Chief Executive, Fareham and Gosport Primary Care Groups

  Dr Pennells, Chairperson, Gosport Primary Care Groups

- Portsmouth Local Medical Committee

  Dr Stephen McKenning, Chairman

- Gosport War Memorial Hospital medical committee

  Dr Warner, Chairman

- Local representative for the Royal College of Nursing

  Betty Woodland, Steward

  Steve Barnes, RCN Officer

GMC100829-0499

- Local representative for Unison

  Patrick Carroll, Branch Chair

- Local general practitioners

  Dr J Barton, Knapman Practice

  Dr P Beasley, Knapman Practice

  Dr S Brook, Knapman Practice

GMC100829-0500

APPENDIX E

Medical case note review team: terms of reference and membership

Terms of reference for the medical notes review group to support the CHI investigation at Gosport War Memorial Hospital

PURPOSE

The group has been established to review the clinical notes of a random selection of recently deceased older patients at the Gosport War Memorial Hospital in order to inform the CHI investigation. With reference to CHI's investigation terms of reference and the expert witness reports prepared for the police by Dr Munday and Professor Ford, this review will address the following:

(i) the prescription, administration, review and recording of drugs

(ii) the use and application of the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs

(iii) the quality of nursing care towards the end of life

(iv) the recorded cause of death

METHOD

The group will review 15 anonymised clinical notes supplied by the trust, followed by a one day meeting at CHI in order to produce a written report to inform the CHI investigation. The group will reach its conclusions by 31 March 2002 at the latest.

MEMBERSHIP

- Dr Tony Luxton, Geriatrician
  Cambridge City PCT
  (CHI doctor team member and chair of the group)
- Maureen Morgan, Independent Management Consultant
  (CHI nurse member)
- Professor Gary Ford, Professor of Pharmacology of Old Age
  University of Newcastle and Freeman Hospital
- Dr Keith Munday, Consultant Geriatrician
  Frimley Park Hospital
- Annette Goulden, Deputy Director of Nursing
  NHS Trent regional office and formerly
  Department of Health Nursing Officer for elderly care

FINDINGS OF GROUP

The findings of the group will be shared with:

(i) the CHI Gosport investigation team

(ii) CHI's Nurse Director and Medical Director and other CHI staff as appropriate

(iii) the trust

(iv) relatives of the deceased (facilitated by the trust) if requested, on an individual basis

The final report of the group will be subject to the rules of disclosure applying to CHI investigation reports.

APPENDIX F

Report of the Gosport investigation medical notes review group

PURPOSE

CHI undertook a review of the anonymised medical notes of a random selection of 15 patients who had died between 1 August 2001 and 31 January 2002 on Daedalus, Dryad or Sultan wards at Gosport War Memorial Hospital.

CHI's intention for this piece of work was to determine whether the policies and systems put in place by the Portsmouth Healthcare NHS Trust since the events of 1998, to address prescribing practices are being implemented and are impacting on the quality of care patients are now receiving. CHI's review also considered the nursing notes for each patient and looked at the quality of nursing care as documented in the notes. Finally, the review considered whether the cause of death recorded in the notes was appropriate.

METHODOLOGY

The group received 15 sets of anonymised medical notes from the trust, which related to the last admission of 15 patients. Five patients were randomly selected from each of the following wards: Daedalus, Dryad and Sultan. A total of 49 patients had died whilst on these wards during the sample timeframe.

FINDINGS

(i) *Use of medicines*

Prescription

The group considered that the volume and combination of medicines used was appropriate for this group of patients and was in line with accepted good practice and British National Formulary guidelines. Single prescription, PRN and syringe driver prescribing was acceptable. There was no evidence of anticipatory prescribing.

The case notes suggested that the use of the trust's 'analgesic ladder' to incrementally increase and decrease pain relief in accordance to need was being followed. The group saw no evidence to suggest that patients had been prescribed large amounts of pain relief, such as diamorphine on admission where this was not necessary. Co-codamol had been prescribed in a number of cases as an initial analgesic, with progression to alternative medicines as and when more pain relief was needed. The use of the analgesic ladder was less evident in Sultan ward.

However, in two cases, the group saw evidence of unacceptable breakthrough pain, and six hourly rather than four hourly prescriptions, which could have allowed this to happen. There was also some evidence of the simultaneous prescribing of co-codamol and fentanyl, which was not thought by the group to be the most effective combination of medicines.

Administration

Syringe drivers had been used to deliver medication to six of the patients reviewed. Appropriate use of syringe drivers as a method of medicine administration was observed, with documented discussions with families before use.

Appropriate administration of medicines by nursing staff was evident. Prescriptions issued over the telephone by GPs on Sultan ward were appropriately completed in accordance with trust policy.

Review and recording of medicines

Evidence of consistent review of medication was seen, with evidence to suggest that patients and relatives were involved in helping to determine levels of pain. Nursing staff had appropriately administered medicines in line with medical staff prescriptions. Prescription sheets had been completed adequately on all three wards. Generally, record keeping around prescribing was clear and consistent, though this was not as clear on Sultan ward.

Based on the medical notes reviewed, the group agreed that the trust's policies on the assessment and management of pain, prescription writing and administration of IV drugs were being adhered to.

(ii) *Quality of nursing care towards the end of life*

The team found a consistently reasonable standard of care given to all patients they reviewed. The quality of nursing notes was generally adequate, although not always of consistent quality. There was some evidence to suggest a task oriented approach to care with an over emphasis on the completion of paperwork. This left an impression of a sometimes disjointed rather than integrated individual holistic assessment of the patient. The team saw some very good, detailed care plans and as well as a number of incidences where no clear agreed care plan was evident.

The team was concerned that swallowing assessments for patients with dysphagia had been delayed over a weekend because of the lack of availability of suitably trained nursing staff. Nurses could be trained to undertake this role in order not to compromise patient nutrition. Despite this, the trust's policies regarding fluid and nutrition were generally being adhered to. Though based on the nursing notes, a number of patients had only been weighed once, on admission.

There was evidence of therapy input, but this had not always been incorporated into care plans and did not always appear comprehensive. There was some concern that despite patients being assessed as at risk of pressure sores, it was not clear how this had been managed for some patients.

There was thorough, documented evidence to suggest that comprehensive discussions were held with relatives and patients towards the end of the patient's life. Do not attempt resuscitation decisions were clearly stated in the medical records.

Recorded cause of death

The group found no cause for concerns regarding any of the stated causes of death.

GENERAL COMMENTS

Admission criteria

The team considered that the admission criteria for Daedalus and Dryad wards was being adhered to. However there were examples of patients admitted to Sultan ward who were more dependent than the admission criteria stipulates. There is also an issue regarding patients who initially meet the admission criteria for Sultan ward who then develop complications and become more acutely sick.

Elderly medicine consultant input and access to specialist advice

Patients on Daedalus and Dryad wards received regular, documented review by consultant staff. There was clear evidence of specialist input, from mental health physicians, therapists and medical staff from the acute sector.

Out of hours cover

There was little evidence of out of hours input into the care of patients reviewed by CHI, though the team formed the view that this had been appropriate and would indicate that the general management of patients during regular hours was therefore of a good standard.

APPENDIX G

An explanation of the dissolution of services into the new primary care trusts

Figure G.1 Arrangements for hosting clinical services

Department	Portsmouth City PCT	East Hampshire PCT	Fareham & Gosport PCT	West Hampshire NHS Trust
Elderly medicine		•		
Elderly mental health		•		
Community paediatrics	•			
Adult mental health services	• For Portsmouth patients			• For Hampshire patients
Learning disability services			•	
Substance misuse	•			
Clinical pyschology	•			
Primary care counselling				•
Specialist family planning	•			
Palliative care		•		

(Source: *Local health, local decisions*, consultation document, September 2001, NHS Executive South East Regional Office, Isle of Wight, Portsmouth and South East Hampshire Health Authority and Southampton and South West Health Authority)

APPENDIX H

Patient throughput data 1997/1998 – 2000/2001

Figure H.1 Throughput data 1997/1998 – 2000/2001

Financial year	Ward	Finished consultant episodes
1997/1998	Daedalus	97
1997/1998	Dryad	72
1997/1998	Sultan	287
	Total	456
1998/1999	Daedalus	121
1998/1999	Dryad	76
1998/1999	Sultan	306
	Total	503
1999/2000	Daedalus	110
1999/2000	Dryad	131
1999/2000	Sultan	402
	Total	643
2000/2001	Daedalus	113
2000/2001	Dryad	86
2000/2001	Sultan	380
	Total	579

(Source: 1997/1998 – trust ward based discharge data, 1998/1999, 1999/2000 and 2000/2001 – trust patient administration system (PAS) data).

GMC100829-0507

APPENDIX I

Breakdown of medication in Dryad, Sultan and Daedalus wards at Gosport War Memorial Hospital

Figure I.1 Summary of medicine usage 1997/1998-2000/2001 (Mar 2002)

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	5mg	5	0	5	0	3
	Dryad	5mg	5	0	0	0	6
	Sultan	5mg	5	6	5	0	10
	Total			6	10	0	19
Diamorphine via syringe driver	Sultan	5mg	1	0	10	0	0
	Total			0	10	0	0
Diamorphine injection	Daedalus	10mg	5	21	34	27	19
	Dryad	10mg	5	40	57	56	20
	Sultan	10mg	5	67	36	24	35
	Total			128	127	107	74
Diamorphine via syringe driver	Dryad	10mg	1	0	17	0	0
	Sultan	10mg	1	0	20	0	0
	Total			0	37	0	0
Diamorphine injection	Daedalus	30mg	5	16	27	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	43	14	31
	Total			117	121	69	42
Diamorphine via syringe driver	Dryad	30mg	1	0	5	0	0
	Total			0	5	0	0
Diamorphine injection	Daedalus	100mg	5	2	11	1	2
	Dryad	100mg	5	12	13	2	0
	Sultan	100mg	5	20	27	0	31
	Total			34	51	3	33

Drug	Ward	Dose	Pack	97/98	98/99	99/00	00/01
Diamorphine injection	Daedalus	500mg	5	0	1	0	0
	Dryad	500mg	5	0	2	0	0
	Sultan	500mg	5	1	1	0	4
	Total			1	4	0	4
Haloperidol injection	Daedalus	5mg/5ml	10	0	3	0	0
	Dryad	5mg/5ml	10	1	1	0	0
	Sultan	5mg/5ml	10	43	15	6	0
	Total			44	19	6	0
Haloperidol injection	Daedalus	5mg/5ml	5	0	0	0	4
	Dryad	5mg/5ml	5	0	0	0	1
	Sultan	5mg/5ml	5	0	0	0	16
	Total			0	0	0	21
Midazolam	Daedalus	10mg/2ml	10	37	51	39	17
	Dryad	10mg/2ml	10	75	108	75	19
	Sultan	10mg/2ml	10	21	9	2	11
	Total			133	168	116	47

(Source: Portsmouth Healthcare NHS Trust)

Dose: a single measured quantity of medicine

Pack: a collection of single doses, the packaging in which medicines are dispatched from the pharmacy

APPENDIX J

Glossary

accountability responsibility, in the sense of being called to account for something.

action plan an agreed plan of action and timetable that makes improvements to services.

acute care/ trust/hospital short term (as opposed to chronic, which means long term).
Acute care refers to medical and surgical treatment involving doctors and other medical staff in a hospital setting.
Acute hospital refers to a hospital that provides surgery, investigations, operations, serious and other treatments, usually in a hospital setting.

allied health professionals professionals regulated by the Council for Professions Supplementary to Medicine (new Health Professions Council). This includes professions working in health, social care, education, housing and other sectors. The professions are art therapists, music therapists and drama therapists, prosthetists and orthotists, dieticians, orthoptists, occupational therapists, physiotherapists, biomedical scientists, speech and language therapists, radiographers, chiropodists and podiatrists, ambulance workers and clinical scientists. Also called professionals allied to or supplementary to medicine.

analgesia medicines prescribed to reduce pain.

anticipatory prescribing to prescribe a drug or other remedy in advance.

antipsychotics A group of medicines used to treat psychosis (conditions such as schizophrenia) and sometimes used to calm agitation. Examples include haloperidol. Also called major tranquillisers or neuroleptics.

appraisal an assessment or estimate of the worth, value or quality of a person or service or thing.

Association of Chief Police Officers (ACPO) an association whose members hold the rank of Chief Constable, deputy Chief Constable or Assistant Chief Constable or their equivalents. They provide a professional opinion to the Government and appropriate organisations.

audit, clinical audit an examination of records to check their accuracy. Often used to describe an examination of financial accounts in a business.
In clinical audit those involved in providing services assess the quality of care. Results of a process or intervention are assessed, compared with a preexisting standard, changed where necessary, and then reassessed.

Barthel score a validated tool used to measure physical disability.

benzodiazepines a diverse group of medicines used for a range of purposes. Some reduce anxiety, others are used as sleeping tablets. Some, such as *midazolam*, act as strong sedatives and can be accompanied by memory loss whilst the medicine is active.

British National Formulary publication that provides information on the selection and use of medicines for healthcare professionals.

carers people who look after their relatives and friends on an unpaid, voluntary basis often in place of paid care workers.

casemix the variety and range of different types of patients treated by a given health professional or team.

catheter a hollow tube passed into the bladder to remove urine.

catheterisation use of a catheter.

CHI see Commission for Health Improvement.

clinical any treatment provided by a healthcare professional. This will include, doctors, nurses, AHPs etc. Non clinical relates to management, administration, catering, portering etc.

clinical assistant usually GPs, employed and paid by a trust, largely on a part time basis, to provide medical support on hospital wards and other departments.

clinical governance refers to the quality of health care offered within an organisation.
The Department of Health document *A First Class Service* defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." It's about making sure that health services have systems in place to provide patients with high standards of care.

clinical governance review a review of the policies, systems and processes used by an organisation to deliver high quality health care to patients. The review looks at the way these policies work in practice (a health check for a health organisation).

clinical oncologist a doctor who specialises in the treatment of cancer patients, particularly through the use of radiotherapy, but who may also use chemotherapy.

clinical risk management understanding the various levels of risk attached to each form of treatment and systematically taking steps to ensure that the risks are minimised.

clinician/clinical staff a fully trained health professional – doctor, nurse, therapist, technician etc.

clinical negligence scheme for trusts (CNST) an 'insurance' scheme for assessing a trust's arrangements to minimise clinical risk which can offset costs of insurance against claims of negligence. Successfully gaining CNST 'standards' (to level one, two, three) reduces the premium that the trust must pay.

Commission for Health Improvement (CHI) independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.

co-codamol a medicine consisting of paracetamol and codeine phosphate, used for the relief of mild to moderate pain.

community care health and social care provided by health care professionals, usually outside hospital and often in the patient's own homes.

community health council (CHC) a statutory body sometimes referred to as the patients' friend. CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.

consultant a fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care. (For training posts in medicine see specialist registrar, senior house officer and preregistration house officer.)

continence management The practice of promoting or sustaning the ability to control urination and defecation.

continuing care a long period of treatment for patients whose recovery will be limited.

defibrillator a piece of equipment which sends an electric current through the heart to restore the heart beat.

diamorphine A medicine used to relieve severe pain.

do not attempt resuscitation (DNAR) or do not resuscitate (DNR) an instruction, which says that if a patient's health suddenly deteriorates to near death, no special measures will be taken to revive their heart. This instruction should be agreed between the patient and doctor or if a patient is not conscious, then with their closest relative.

dysphagia difficulty swallowing.

fentanyl a medicine prescribed to patients who require control of existing pain.

finished consultant episode (FCE) a period of continuous consultant treatment under a specific consultant. If a patient is transferred from one consultant to another it will be counted as two FCEs.

formulary a list of preferred medicinal drugs which are routinely available in a hospital or GP surgery.

General Medical Council (GMC) the professional body for medical doctors which licenses them to practice.

general practitioner (GP) a family doctor, usually patients' first point of contact with the health service.

geriatrician a doctor who specialises in diagnosis and treatment of diseases affecting older people.

haloperidol see antipsychotics.

health authority (HA) statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities.

health community or health economy all organisations with an interest in health in one area including the community health councils, and voluntary and statutory organisations.

Health Service Ombudsman investigates complaints about failures in NHS hospitals or community health services, about care and treatment, and about local NHS family doctor, dental, pharmacy or optical services. Anyone may refer a complaint but normally only if a full investigation through the NHS complaints system has been carried out first.

holistic a method of medical care in which patients are treated as a whole and which takes into account their physical and mental state as well as social background rather than just treating the disease alone.

hyocine a medicine to relieve nausea and sickness.

Improving Working Lives a Department of Health initiative launched in 1999. It includes standards for developing modern employment services, putting in place work/life balance schemes and involving and developing staff.

incident reporting system a system which requires clinical staff to report all matters relating to patient care where there has been a special problem.

independent review stage two of the formal NHS complaints procedure, it consists of a panel, usually three members, who look at the issues surrounding a complaint.

intermediate care a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.

intranet an organisation's own internal internet which is usually private.

investigation – by CHI an in depth examination of an organisation where a serious problem has been identified.

Investors in People a national quality standard which sets a level of good practice for improving an organisation's performance through its people.

lay member a person from outside the NHS who brings an independent voice to CHI's work.

local medical committee (LMC) a group of local GPs, elected by the entire local GP population who meet with the health authority to help plan resources and inform decisions.

locum a temporary practitioner who stands in for the permanent one.

medical the branches of medicine concerned with treatment through careful use of medicines as opposed to (surgical) operations.

medical director the term usually used for a doctor at trust board level (a statutory post) responsible for all issues relating to doctors and medical and surgical issues throughout the trust.

midazolam see benzodiazepines.

multidisciplinary from different professional backgrounds within healthcare (e.g. nurse, consultant, physiotherapist) concerned with the treatment and care of patients.

multidisciplinary meetings meetings involving people from different professional backgrounds.

multiprofessional from different professional backgrounds, within and outside of healthcare (e.g. nurse, consultant, social worker) concerned with the care or welfare of people.

GMC100829-0512

National Service Framework (NSF) guidelines for the health service from the Department of Health on how to manage and treat specific conditions, or specific groups of patients e.g. Coronary Heart Disease, Mental Health, NSF for older people. Their implementation across the NHS is monitored by CHI.

neuroleptic see antipsychotics.

neurology a branch of medicine concerned with medical treatment of disorders of the nervous system.

NHS regional office

NHS trust a self governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.

Nursing and Midwifery Council The Nursing Midwifery Council (NMC) is an organisation set up by Parliament to ensure nurses, midwives and health visitors provide appropriate standards of care to their patients and clients. All qualified nurses, midwives and health visitors are required to be members of the NMC in order to practice.

nursing director the term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing throughout the trust.

occupational therapist a trained professional (an allied health professional) who works with patients to assess and develop daily living skills and social skills.

ombudsman see national health service ombudsman above.

opiates a group of medicines containing or derived from opium, that act to relieve severe pain or induce sleep.

opioid a description applied to medicines that cause similar effects in the body to opiates.

outpatient services provided for patients who do not stay overnight in hospital.

pain management a particular type of treatment that concentrates on managing a patient's pain – rather than seeking to cure their underlying condition – and complements their treatment plan.

palliative a term applied to the treatment of incurable diseases, in which the aim is to mitigate the sufferings of the patient, not to effect a cure.

palliative care care for people with chronic or life threatening conditions from which they will not recover. It concentrates on symptom control and family support to help people have as much independence and quality of life as is possible.

patient administration system (PAS) a networked information system used in NHS trusts to record information and inpatient and outpatient activity.

patient advice and liaison service (PALS) a new service proposed in the July 2000 NHS plan due to be in place by 2002, that will offer patients an avenue to seek advice or complain about their hospital care.

patient centred care a system of care or treatment is organised around the needs of the patient.

patient involvement the amount of participation that a patient (or patients) can have in their care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

primary care family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

PCG Organisations now almost completely replaced by primary care trusts. Set up in 1997, PCGs were new organisations (technically Health Authority committees) that brought together all primary care practices in a particular area. PCGs were led by primary care professionals but with lay and social services representation. PCGs were expected to develop local primary health care services and work to improve the health of their populations. Some PCGs additionally took responsibility for commissioning secondary care services.

PCT Organisations that bring together all primary care practices in an area. PCTs are diverse and complex organisations. Unlike PCGs, which came before them, they are independent NHS bodies with greater responsibilities and

powers. They were set up in response to the Department of Health's *Shifting the Balance of Power* and took over many health authority functions. PCTs are responsible for

- improving the health of their population
- integrating and developing primary care services
- directly providing community health services
- commissioning secondary care services

PCTs are increasingly working with other PCTs, local government partners, the voluntary sector, within clinical networks and with 'shared service organisations' in order to fulfil their roles.

level four PCT brings together commissioning of secondary care services and primary care development with the provision of community health services. They are able to commission and provide services, run community health services, employ the necessary staff, and own property.

PRN (Pro re nata) prescribing medication as and when required.

protocol a policy or strategy which defines appropriate action.

psychiatrist a doctor who specialises in the diagnosis and treatment of mental health problems.

regional office see NHS regional office above.

rehabilitation the treatment of residual illness or disability which includes a whole range of exercise and therapies with the aim of increasing a patient's independence.

resuscitation a range of procedures used when someone has suddenly become seriously ill in a way that threatens their life.

risk assessment an examination of the risks associated with a particular service or procedure.

risk management understanding the various risks involved and systematically taking steps to ensure that the risks are minimized.

Royal College of Nursing (RCN) the world's largest professional union of nurses. Run by nurses, it campaigns on the part of the profession, provides higher education and promotes research, quality and practice development through the RCN institute.

sensory disabilities people who have problems hearing, seeing, smelling or with touch.

specialist a clinician most able to progress a patient's diagnosis and treatment or to refer a patient when appropriate.

speech and language therapist professionally trained person who assists, diagnoses and treats the whole spectrum of acquired or developmental communication disorders.

staff grade a full qualified doctor who is neither a General Practitioner nor a consultant.

staff grade doctors doctors who have completed their training but do not have the qualifications to enable them to progress to consultant level. Also called trust grade doctors.

stakeholders a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation. In the case of hospital trusts, it includes patients, carers, staff, unions, voluntary organisations, community health councils, social services, health authorities, GPs, primary care groups and trusts in England, local health groups in Wales.

statutory/statute refers to legislation passed by Parliament.

strategic health authority organisations that will replace health authorities and some functions of Department of Health regional offices in 2002. Unlike current health authorities, they will not be involved in commissioning services from the NHS. Instead they will performance manage PCTs and NHS trusts and lead strategic developments in the NHS. Full details of the planned changes are in the Department of Health document, Shifting the Balance of Power, July 2001.

strategy a long term plan for success.

subcutaneous beneath the skin.

swallowing assessments the technique to access the ability of the patient to swallow safely.

syringe driver a device to ensure that a syringe releases medicine over a defined length of time into the body.

terminal care care given in the last weeks of life.

terms of reference the rules by which a committee or group does its work.

trust board a group of about 12 people who are responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and directors.

Unison Britain's biggest trade union. Members are people working in the public services.

United Kingdom Central Council (UKCC) on 1 April 2002 the UKCC ceased to exist. Its successor body is The Nursing and Midwifery Council (NMC). Its purpose was to protect the public through establishing and monitoring professional standards.

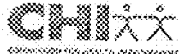
ward round A regular review of each patient conducted by a consultant, often accompanied by nursing, pharmacy and therapy staff.

Wessex palliative care guidelines local guidance to help GPs, community nurses and hospital staff as well as specialist palliative care teams. It provides a checklist for management of common problems in palliative care, with some information on medical treatment. It is not a comprehensive textbook.

whistle blowing the act of informing a designated person in an organisation that patients are at risk (in the eyes of the person blowing the whistle). This also includes systems and processes that indirectly affect patient care.

whistle blowing policy a plan of action for a person to inform on someone or to put a stop to something.

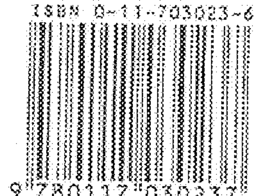
Printed in the United Kingdom by The Stationery Office
07/02 745413 19585

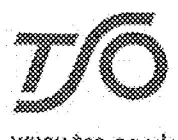


Commission for Health Improvement
Finsbury Tower
103–105 Bunhill Row
London EC1Y 8TG

Telephone: 020 7448 9200
Fax: 020 7448 9222
Text phone: 020 7448 9292
Web: www.chi.nhs.uk

Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital – July 2002


ISBN 0-11-703023-6
9 780117 030237


www.tso.co.uk

HAMPSHIRE CONSTABULARY

v

DR JANE BARTON

Volume 2 (of 2)
(IOC Papers)

Hampshire Constabulary v Dr Jane Barton, Volume 2 (of 2) (IOC Papers)

Document	Relates to
Transcript of IOC 21/03/02	Page, Richards, Wilkie, Cunningham, Wilson
Transcript of IOC 19/09/02 - no order made	Page, Richards, Wilkie, Cunningham, Wilson
IOC Bundle of 21/06/01:- - GMC letter of referral to IOC - Correspondence from police to GMC - Witness statement of Lesley Lack - Witness statement of Gillian MacKenzie - Medical records of Gladys Richards - Statement of Dr Barton - Report of Dr Lord (22/12/98)	 Gladys Richards
IOC Bundle of 21/03/02:- - GMC letter of referral to IOC - Bundle from IOC on 21/06/01 - Transcript of hearing on 21/06/01 - Report of Professor Livesley - Report of Dr Mundy - Report of Professor Ford - Information received from Portsmouth Healthcare NHS Trust re restrictions on practise - Information received from Isle of Wight, Portsmouth and South East Hampshire Health Authority re practise restrictions	 Richards only All 5 cases All 5 cases
IOC Bundle of 19/09/02:- - GMC letter setting out allegations - Correspondence between GMC and Police - Livesley Report - Mundy Report - Ford Report - Letter from Gillian MacKenzie - Letter from Charles Farthing - Letter from M Jackson - Letter from Iain Wilson - Letter from Bernard Page - Statement of Lesley Lack - Statement of Gillian MacKenzie - Statement of Dr Barton - Police interview with Dr Lord - Police interview with Dr Beed - Dr Barton's written response for PPC - Transcript of IOC on 21/03/02	 Richards Cunningham Wilkie Wilson Page Richards Richards Richards Richards Richards Various Various

E:\c\ioc\item\Barton 02 09

Confidential

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee

19 September 2002

New case of conduct

BARTON, Jane Ann

BM BCh 1972 Oxford

Code A

Specialty: GP

Current Employer: Hampshire and Isle of Wight Practitioner and Patient Services Agency

Other interested parties: Police, CMO and Department of Health

Legal representation: Mr Ian Barker, Medical Defence Union

Code A

FPD Reference and Name of caseworker: Code A **Michael Keegan/Venessa Carroll**

Nature of case: Inappropriate prescribing/substandard clinical practice

Reason for referral to IOC : The CPS are now reconsidering the five cases and the case has been referred for an inquiry by the Professional Conduct Committee.

Previous history: None

Case history: The Preliminary Proceedings Committee referred this case for an inquiry by the Professional Conduct Committee on 29 August 2002.

Index of papers

Item considered by the Preliminary Proceedings Committee on 29 August 2002 — Pages 1 to 432

For detailed index see page 2

Index of papers

Item considered by the Preliminary Proceedings Committee on 29 August 2002	Pages 1 to 432

For detailed index see page 2

AGENDA ITEM: 17.

2000/ 2047

Date Rule 6 Letter sent: 11 July 2002

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Confidential

Preliminary Proceedings Committee

29 - 30 August 2002

New case of conduct

Name and Personal Details	Type of Case
BARTON, Jane Ann BM BCh 1972 Oxfd General Practice d.o.b. **Code A**	Sub-standard clinical practice and care (inappropriate/irresponsible prescribing)

Members' Notes

Please note that those documents listed at page 3 are not copied in the committee papers but will be available for scrutiny on the day of the meeting

Information case

Previous history: None

This case has been prepared by: Michael Hudspith - 020 7915 3617 e:\conduct\mike\ppc\barton

Index of papers

	Pages
Index of exhibits	3
GMC letter setting out allegations	4 - 8
Correspondence received from Hampshire Constabulary (07/00 - 02/02)	9 - 18
Expert opinion of Prof Livesley (case of Richards)	19 - 52
Expert opinion of Dr Mundy (cases of Cunningham, Wilkie, Wilson, Page)	53 - 58
Expert opinion of Prof Ford (cases of Richards, Cunningham, Wilkie, Wilson, Page)	59 - 97
Letter received from Gillian MacKenzie (daughter of Gladys Richards)	98 - 99
Letter received from Charles Farthing (step-son of Arthur Cunningham)	100
Letter received from Mrs M Jackson (daughter of Alice Wilkie)	101 - 103
Letter received from Iain Wilson (son of Robert Wilson)	104
Letter received from Bernard Page (son of Eva Page)	105
The following documents relate specifically to the case of Gladys Richards	
Witness statement of Lesley Lack	106 - 125
Witness statement of Gillian MacKenzie	126 - 152
Statement of Dr Jane Barton	153 - 163
Record of police interview with Dr Althea Lord (Consultant in Elderly Medicine)	164 - 233
Record of police interview with Philips Beed (Clinical Manager/Charge Nurse)	234 - 399
Screener's memorandum	400 - 403

Exhibits received from police - not copied in the committee papers

	Pages
Medical records for Gladys Richards (July - Aug 1998)	1 - 131
Medical records for Arthur Cunningham (Sept 1998)	132 - 197
Medical records for Alice Wilkie (July - Aug 1998)	198 - 270
Medical records for Robert Wilson (Sept - Oct 1998)	271 - 407
Medical records for Eva Page (Feb - Mar 1998)	408 - 509

The following documents relate specifically to the case of Gladys Richards

Witness statement of Sylvia Giffin (Staff Nurse)	510 - 514
Record of police interview with Sylvia Giffin (Staff Nurse)	515 - 575
Record of police interview with Catherine Marjoram (Staff Nurse)	576 - 638
Record of police interview with Geraldine McCarthy (Health Care Support Worker)	639 - 640
Record of police interview with Jean Moss (Nursing Auxilliary)	641 - 683
Record of police interview with Margaret Perkins (Nursing Auxilliary(?))	684 - 713
Record of police interview with Monica Pulford (Nurse)	714 - 750
Witness statement of Minh Rushton (Health Care Support Worker)	751 - 753
Record of police interview with Anita Tubbritt (Staff Nurse)	754 - 793
Record of police interview with Christina Tyler (Health Care Support Worker)	794 - 855
Record of police interview with Fiona Walker (Nurse)	856 - 884
Record of police interview with Kathleen Wallington (Health Care Support Worker)	885 - 916
Witness statement of Katherine Wilde (Health Care Support Worker)	917 - 918
Record of police interview with Dr Barton (Dr Barton makes 'no comment' on the advice of her solicitor)	919 - 925
Witness statement of Anne Funnell, Medical Records Manager	926
Witness statements of Lesley Humphrey, Quality Manager	927 - 936
Summary prepared by Dr Lord	937 - 938
Extract from Toxic Psychiatry by Dr Peter Breggin	939 - 943
Extract from Criminal Law by Diana Rowe	944 - 957

In reply please quote 2000/2047

Please address your reply to the Fitness to Practise Directorate
Fax: 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

11 July 2002

Special Delivery

Dr J A Barton

Code A

Dear Dr Barton

A member of the Council, who is appointed under Rule 4 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 to give initial consideration to cases, has asked me to notify you, under rule 6(3) of those Rules, that the Council has received from Hampshire Constabulary information which appears to raise a question whether, as a registered medical practitioner, you have committed serious professional misconduct within the meaning of section 36(1) of the Medical Act 1983. A copy of the relevant provisions of the Act is enclosed, together with copies of the Procedure Rules, the GMC's publication "Good Medical Practice" and of a paper about the GMC's fitness to practise processes.

In the information it is alleged that:

1. At the material times you were a registered medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Hampshire;

2. a. i. On 27 February 1998, Eva Page was admitted to Dryad Ward at Gosport War Memorial Hospital for palliative care having being diagnosed at the Queen Alexander Hospital with probable carcinoma of the bronchus

ii. On 3 March 1998 you prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously via syringe driver

b. Your prescribing to Mrs Page of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. she was started on opioid analgesia in the absence of prior psychogeriatric advice

ii. the medical and nursing records do not indicate that Mrs Page was distressed or in pain

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Page's condition;

3. a. i. On 6 August 1998 Alice Wilkie was admitted to Daedalus Ward at Gosport War Memorial Hospital for observation following treatment at the Queen Alexandra Hospital for a urinary tract infection

ii. You prescribed diamorphine, hyoscine and midazolam to be administered subcutaneously

iii. These drugs were administered to Mrs Wilkie from 20 August 1998 until her death the following day

iv. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her time on Daedalus Ward prior to this

b. Your prescribing to Mrs Wilkie of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the prescription for diamorphine, hyoscine and midazolam was undated

iii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs were not adequately recorded in medical or nursing records

iv. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Wilkie's condition

c. Your management of Mrs Wilkie was unprofessional in that you failed to pay sufficient regard to Mrs Wilkie's rehabilitation needs;

4. a. i. On 11 August 1998 Gladys Richards was admitted to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation following a hip replacement operation performed on 28 July 1998 at the Haslar Hospital, Southampton

ii. Despite recording that Mrs Richards was 'not obviously in pain' you prescribed oromorph, diamorphine, hyoscine, midazolam and haloperidol

iii. Although Mrs Richards did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. On 13 August 1998 Mrs Richards artificial hip joint became dislocated and underwent further surgery at the Haslar Hospital, returning to Daedalus ward on 17 August 1998

v. On 18 August 1998 you prescribed diamorphine, haloperidol, midazolam and, on 19 August 1998, hyoscine which was administered to Mrs Richards subcutaneously and by syringe driver until her death on 21 August 1998

vi. Between 18 and 21 August 1998 Mrs Richards received no foods or fluids

b. Your prescribing to Mrs Richards of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. you knew or should have known that Mrs Richards was sensitive to oromorph and had had a prolonged sedated response to intravenous midazolam

ii. insufficient regard was given to the possibility of using milder or more moderate analgesics to control Mrs Richards pain

iii. opiate and sedative drugs were administered subcutaneously when you knew or should have known that Mrs Richards was capable of receiving oral medication

iv. You knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richards' condition

d. Your management of Mrs Richards was unprofessional in that you failed to pay sufficient regard to Mrs Richards' rehabilitation needs.;

5. a. i. On 21 September 1998 Arthur Cunningham was admitted to Dryad ward at Gosport War Memorial Hospital with a large sacral necrotic ulcer with necrotic area over the left outer aspect of the ankle

ii. After reviewing Mr Cunningham you prescribed oromorph and later, via syringe driver, diamorphine, midazolam to which was added hyoscine on 23 September

iii. Although Mr Cunningham did not have a specific life threatening or terminal illness you noted in the medical records that you were 'happy for nursing staff to confirm death'

iv. Dosages were increased daily between 23 September 1998 and Mr Cunningham's death on 26 September 1998

b. Your prescribing to Mr Cunningham of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. insufficient regard was given to the possibility of alternative milder or more moderate treatment options

ii. the reasons for the switch to subcutaneous infusion and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Cunningham's condition

c. Your management of Mr Cunningham was unprofessional in that you failed to pay sufficient regard to Mr Cunningham's rehabilitation needs;

6. a. i. On 14 October 1998 Robert Wilson was transferred from to Dryad Ward at Gosport War Memorial Hospital for rehabilitation, following treatment at the Queen Alexandra Hospital for a fractured left humerus

ii. Between 16 October 1998 and Mr Wilson's death on 18 October 1998 you prescribed oromorph, diamorphine, hyoscine and midazolam

iii. Diamorphine, hyoscine and midazolam were administered subcutaneously to Mr Wilson via syringe driver from 16 October 1998

b. Your prescribing to Mr Wilson of opiate and sedative drugs was inappropriate and/or unprofessional in that

i. the prescription for diamorphine, hyoscine and midazolam was undated

ii. the specific reasons for commencing subcutaneous infusion of opiate and sedative drugs and the subsequent increases in dosages were not adequately recorded in medical or nursing records

iii. you knew or should have known that opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mr Wilson's condition

c. Your management of Mr Wilson was unprofessional in that you failed to pay sufficient regard to Mr Wilson's rehabilitation needs.

Copies of information from Hampshire Constabulary may be found in the enclosed bundle of papers which is indexed at page 2.

The member has directed, in accordance with the Procedure Rules, that the information received from Hampshire Constabulary be referred to the Preliminary Proceedings Committee of the Council. That Committee will consider the information any written explanation provided by you, to determine whether the case should be referred to the Professional Conduct Committee of the Council for inquiry into a charge against you.

You are invited to submit at your earliest convenience a written explanation of the foregoing matter. The next meeting of the Preliminary Proceedings Committee will be held on 29 - 30 August 2002. It is in your interests that the Committee should have time to give careful consideration to any explanation you may wish to offer. You may therefore find it helpful to know that any explanation received by the Council before 21 August 2002 will be circulated to the Committee before the meeting. Any explanation received between 21 and 29 August 2002 will be placed before the Committee on the day of the meeting. Please address your explanation for the attention of Lorna Johnston, Conduct Case Presentation Team, fax number: 0207 915 3696.

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 10 days of receipt of this letter, of the name and address of all of your current employers including the Health Authority with which you have a service agreement, any locum agencies with whom you are registered, and the hospital or 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 or hospital by which you are employed, or have any working arrangements. If you are approved under Section 12 of the Mental Health Act, you must also notify us of this fact.

I enclose a form for you to complete and return in the envelope provided. 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. **Failure to comply with this statutory requirement may result in further proceedings against you.**

The documents enclosed with this letter may contain confidential material. This material is sent to you solely to enable you to respond to the allegations in this letter: it 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 shown above.

Yours sincerely

Code A

Gerry Leighton
Assistant Registrar

2000/2047

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Tel. 0845 045 45 45
Extn: 684-220/349
Fax. 023 92891562

27/07/00

The Fitness to Practice Directorate
General Medical Council,
178 Great Portland Street,
London,
WIN 6JE.
For the attention of Miss BANNISTER

Private and Confidential

Dear Miss Bannister,

Re: Dr. Jane BARTON G.P.

Further to my telephone call of yesterday's date, I wish to provide brief details of an investigation which is currently being conducted by the Hampshire Constabulary.

An allegation has been made by members of the family of a woman named Gladys RICHARDS to the effect that she was unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital (GWMH) during or about the period 17th-21st August 1998. The doctor who appears to have been responsible for the care of Mrs RICHARDS at the time is Dr. Jane BARTON (born: 19.10.48) who is a General Practitioner practising in Gosport, Hampshire. Dr. BARTON is additionally engaged by the Portsmouth Healthcare (NHS) Trust as a visiting Clinical Assistant at the GWMH. Dr. BARTON currently practises at The Surgery, 148 Forton Road, Gosport, Hampshire. The investigation is ongoing and no criminal charges have been preferred. Dr. BARTON is represented by Mr. Ian BARKER of HEMSONS (Solicitors) of London.

If you require any further information, please do not hesitate to contact me.

Yours sincerely

Code A

R. J. BURT
Acting Detective Superintendent

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Police Station
Kingston Crescent
Portsmouth
Hampshire
PO2 8BU

Our Ref. HQ/CID/SE/DCI/2000

Your Ref.

Tel. 0845 045 45 45
Ext: 684-220
Fax. 023 92891504

20/09/00

Ms W Bannister
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 6JE

IN CONFIDENCE

Dear Ms Bannister,

Re: Dr Jane BARTON G.P.

My letter of the 18/9/00, and yours of the 19/9/00, appear to have crossed in the post.

The investigation is ongoing and a file will be submitted to the Crown Prosecution Service as soon as possible. I would estimate that the outcome is unlikely to be known for at least 3 - 4 months.

Dr BARTON has not been charged with any criminal offence.

Yours sincerely

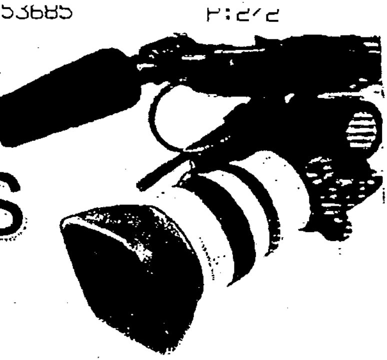
Code A

R J BURT
Detective Chief Inspector

GMC100829-0532

Suki
As discussed Stephanie

MEDIA SERVICES
NEWS RELEASE



OPERATION ROCHESTER

Police have completed their investigation into the circumstances surrounding the death of a 91-year-old woman from Lee on Solent following a complaint by her family.

She died in August 1998 at the War Memorial Hospital in Gosport after being transferred there from Royal Hospital Haslar.

In line with patient confidentiality we cannot reveal the nature of her medical condition.

A file has have been sent to the Crown Prosecution Service and police are awaiting its decision.

We have the full co-operation of the Portsmouth HealthCare (NHS) Trust and the Royal Hospital Haslar for our investigation.

Ends Code A Pauline Davey Code A

11

Hampshire Constabulary Media Services
Police Headquarters, Romsey Road,
Winchester SO22 5DB
T: 01962 871619 F: 01962 871194
mediaservices@hampshire.police.uk

www.hampshire.police.uk

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fratton Police Station
Kingston Crescent
Portsmouth
North End
Portsmouth
PO2 8BU

Our Ref. : Op Rochester

Your Ref. :

Tel. : 0845 045 45 45
Direct Dial : Code A
Fax. : 023 9289 1504

06 June 2001

Ms J Smith
General Medical Council
178 Great Portland Street
London
W1N 6JE

Dear Ms Smith

GENERAL MEDICAL COUNCIL – DR JANE BARTON

I have been asked by DCI Ray BURT to provide you with the following documentation all previously disclosed to Dr BARTON.

1. Statement of Lesley LACK
2. Statement of Gillian MACKENZIE
3. Medical notes Gladys RICHARDS

Please accept my apologies for not supplying them earlier I have been on leave.

Yours Sincerely

Code A

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM

Your Ref. : 2000/2047 -MH

Tel. : 0845 045 45 45
Direct Dial :
Fax. : 023 9289 1504

14 August 2001

Ms J Smith
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1N 7JJ

Dear Ms Smith

Re: Dr Jane BARTON

I am writing to notify you that on Friday 10th August 2001, I received written confirmation from the Crown Prosecution Service informing me of Senior Treasury Counsel's advice regarding the matters about which Dr BARTON was interviewed by the Police.

The advice is that, based on the papers submitted to the Crown Prosecution Service by Hampshire Constabulary, there is insufficient evidence to support a viable prosecution against Dr BARTON with regard to the death of Mrs Gladys RICHARDS.

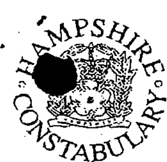
As Senior Investigating Officer for the enquiry I have accepted this advice.

In the absence of any other significant evidence being forthcoming no further action will be taken against Dr BARTON in relation to the death of Mrs Gladys RICHARDS.

I must advise you that following publicity concerning the enquiry into Mrs RICHARDS death a number of members of the public have contacted the enquiry team expressing concerns about the circumstances attendant to the deaths of relatives who had died at the Gosport War Memorial Hospital. I must further advise you that we are conducting preliminary enquiries to determine whether or not these other matters should be the subject of a more intensive police investigation.

Website – www.hampshire.police.uk

CRIMESTOPPERS 0800 555 111



HAMPSHIRE Constabulary

I anticipate that these enquiries will be completed within the next six to eight weeks. I will advise you at the earliest opportunity of the outcome of our investigation.

Yours sincerely

Code A

J JAMES
Detective Superintendent

CRIMESTOPPERS 0800 555 111

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM
Your Ref. :

Tel. : 0845 045 45 45
Direct Dial :
Fax. : 023 9289 1884

06 February 2002

Ms J Smith
Fitness to Practice Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Ms Smith

Re: Dr Jane BARTON and Dr Anthea Everista Geredith LORD

I am writing following my letter to you of the 14th august 2001, concerning police investigations into patient deaths at Gosport War Memorial Hospital. You will note that this correspondence referred to preliminary police investigations to determine whether or not an intensive investigation of deaths at Gosport War Memorial Hospital was warranted.

In furtherance of those investigations expert reports were commissioned in respect of four other patient deaths and a further review of a particular death, Gladys RICHARDS in August 1998, which was previously subject of correspondence with the GMC. Receipt of the further reports was delayed for a number of reasons beyond our control.

However, they have now been reviewed and it has been determined that at this stage no further police investigations are appropriate. This decision is subject to review should further substantial evidence become available.

In reviewing the reports (which are enclosed) it is clear that the commentary and conclusions of the authors raise very serious concerns about the standard of clinical and nursing care delivered to the named patients at Gosport War Memorial Hospital. Specifically the care delivered by Dr BARTON is subject to particular criticism and raises concerns about her professional conduct. To a lesser extent there are implicit concerns about the professional conduct of Dr LORD as the consultant physician who had overall responsibility for patients on Daedulus and Dryad wards at Gosport War Memorial Hospital.

CRIMESTOPPERS 0800 555 111

Website – www.hampshire.police.uk

HAMPSHIRE Constabulary

It is my conclusion that the reports should be disclosed to you as the regulatory body for the named individuals for your action as appropriate. I should further advise that disclosure to you is for the purpose as described on the advice of our Force solicitor and disclosure to any third party should be referred back to us in the first instance.

If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Code A

J JAMES
Detective Superintendent

c.c. Julie MILLER
Investigations Manager
Commission for Health Improvement

CRIMESTOPPERS 0800 555 111

HAMPSHIRE Constabulary

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Major Incident Complex
Kingston Crescent
North End
Portsmouth
PO2 8BU

Our Ref. : MIC/Det.Supt/JJ/DM
Your Ref. : 2000/2047

Tel. : 0845 045 45 45
Direct Dial :
Fax. : 02392 891884

14 February 2002

Mr M Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
LONDON
W1W 5JE

Dear Mr Hudspith

Re: Dr Jane BARTON

I am writing following your letter of the 7th February and our conversation of the 13th concerning the above named.

As I outlined to you the enquiry at Gosport War Memorial Hospital has generated a significant amount of documentation.

In the first instance, as agreed, I will arrange for you to be copied:

- Any statements/reports referred to in the LIVESLEY, FORD, MUNDY reports.
- Patient notes for any person referred to in the above reports.
- Any other obvious supporting documentation.

I will arrange for Detective Sergeant Dave SACKMAN to collate the papers. If you have any queries he can be contacted on 023 9289 1999.

HAMPSHIRE Constabulary

Should you, after receiving the first tranche of documents, identify further material you would like disclosed please contact David direct.

If I can be of any other assistance please advise.

Yours sincerely

Code A

J JAMES
Detective Superintendent

Website – www.hampshire.police.uk

CRIMESTOPPERS 0800 555 111

Medical Report:
concerning the case of Gladys Mable Richards deceased

Prepared for:

Hampshire Constabulary
Major Crime Complex, Fratton Police Station, Kingston Crescent,
North End, Portsmouth, Hampshire PO2 8BU

by: Professor Brian Livesley MD FRCP
The University of London's Professor in the Care of the Elderly
Imperial College School of Science, Technology, & Medicine
The Chelsea and Westminster Hospital, London SW10 9NH

For the purpose of … providing an independent view about treatment given to Mrs Gladys RICHARDS and the factor(s) associated with her death.

Synopsis

1. At the age of 91 years, Mrs Gladys RICHARDS was an in-patient in Daedalus ward at Gosport War Memorial Hospital.

1.1. A registered medical practitioner prescribed the drugs diamorphine, haloperidol, midazolam, and hyoscine for Mrs Gladys RICHARDS.

1.2. These drugs were to be administrated subcutaneously by a syringe driver over an undetermined number of days.

1.3. They were given continuously until Mrs RICHARDS became unconscious and died.

1.4. During this period there is no evidence that Mrs RICHARDS was given life sustaining fluids or food.

1.5. It is my opinion that as a result of being given these drugs, Mrs RICHARDS's death occurred earlier than it would have done from natural causes.

CONTENTS

page no.

1. The writer's declaration 3
2. Introduction 3
3. Information relating to Mrs Gladys RICHARDS (deceased) 3
4. Relevant aspects of Mrs RICHARDS's medical history 4
5. Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital 11
6. Death certification and cremation 14
7. Conclusions 14
8. My opinion 16
9. Appendix A – the documents I have received and read 18
10. Appendix B – facts of the environment obtained from the statements of Mrs RICHARDS's daughters 22
11. Appendix C – Glossary 28
12. Appendix D – Texts used for reference 30
13. Appendix E – My qualifications and experience 31
14. My signature and dating of this report 34

The writer's declaration

1. This report consisting of thirty-four pages is true to the best of my knowledge and belief and I make it knowing that if tendered in evidence, I shall be liable for prosecution if I have wilfully stated in it anything that I know to be false or do not believe to be true.

Introduction

2. The documents with which I have been provided and the visits I have made to the hospitals involved in this enquiry are listed in the Appendix A.

2.1. Appendix B contains facts of the environment provided by the statements of Mrs Gillian MACKENZIE (the elder daughter of Mrs Gladys RICHARDS (deceased)) and Mrs Lesley Frances LACK (the younger daughter).

2.2. I have indicated any medical terms in **bold type**. I have defined these terms in a glossary in Appendix C.

2.3. I have included in Appendix D references to published material.

2.4. Appendix E contains details of my qualifications and experience.

2.5. 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.

Information relating to Mrs Gladys Richards (deceased)

3. Mrs Gladys Mable RICHARDS (née Beech) was born on **Code A** and died on 21st August 1998 aged 91 years.

3.1. Mrs Richards has two daughters. They are Mrs Gillian MACKENZIE (the elder daughter) and Mrs Lesley Frances LACK.

3.1.1. Mrs Lack is a retired Registered General Nurse. She retired during 1996 after 41 years continuously in the nursing profession. For 25 years prior to her retirement she was involved in the care of elderly people. For 20 years prior to retirement she held supervisory and managerial positions in this particular field of nursing.

3.2. The Glen Heathers Nursing Home is a private registered nursing and residential home at Lee on the Solent, Hampshire. Dr J BASSETT is a general practitioner who visits.

3.3. The Royal Hospital Haslar is an acute general hospital in Gosport, Hampshire serviced by the Armed Forces at the time of the incident but available as a National Health Service facility to local people.

3.4. Gosport War Memorial Hospital is part of the Portsmouth Healthcare NHS Trust.

3.4.1. Daedalus ward is a continuing care and rehabilitation ward at Gosport War Memorial Hospital.

3.5. Dr Jane Ann BARTON is a registered medical practitioner who in 1988 took up a part-time post as clinical assistant in elderly medicine. This post became centered at Gosport War Memorial Hospital. She retired from this part-time post in the year 2000.

3.6. Mr Philip James BEED is the clinical manager and charge nurse on Daedalus ward at Gosport War Memorial Hospital. Ms Margaret COUCHMAN and Ms Christine JOICE are registered general nurses who were working on Daedalus ward at the time of the incident.

3.7. Dr Anthea Everista Geredith LORD is a consultant physician, within the department of elderly medicine of Portsmouth Healthcare NHS Trust, who was usually responsible for the patients on Daedalus ward and who was on study leave on 17/18 August 1998.

3.7.1. Other consultant physicians from the department of elderly medicine provide on-call consultant physician cover when Dr LORD is absent from duty.

Relevant aspects of Mrs RICHARDS's medical history

4. Mrs RICHARDS became resident at the Glen Heathers Nursing Home on 5th August 1994 at the age of 87 years and although disorientated and confused she was able to wash and dress herself and able to go up and down stairs and walk well.

4.1. It is noted that she also had a past medical history of bilateral deafness for which she required hearing aids.

4.1.1. Unfortunately both of her hearing aids were lost by December 1997 while she was at the Glen Heathers Nursing Home and had not been replaced by July 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital).

4.1.2. It is noted that on 8th July 1998 her general practitioner, Dr J BASSETT wrote to the audiologist at Queen Alexandra Hospital, Cosham requesting an '**URGENT** [sic]' domiciliary visit to Glen Heathers Nursing Home. This was '... with a view to supplying her [Mrs RICHARDS] with two new hearing aids.... Since her poor hearing probably contributes to her

confusional state I would be grateful if you would visit with a view to fitting of replacement aids as soon as possible please.'

4.2. It is also noted that Mrs RICHARDS had had operations for the removal of cataracts and required glasses.

4.2.1. Unfortunately her spectacles were also lost at the Glen Heathers Nursing Home and had not been replaced by August 1998 when she was admitted to Daedalus ward at Gosport War Memorial Hospital.

4.2.2. As Dr BASSETT had noted Mrs RICHARDS poor hearing probably contributed to her confusional state. The absence of her spectacles would also make it difficult for Mrs RICHARDS to be aware of what was going on around her, further aggravate her confusional state due to lack of sensory stimulation, and increase her dependency on others for her normal daily activities.

4.2.3. The absence of both her hearing aids and her spectacles would make the assessment of and communication with Mrs RICHARDS extremely difficult.

4.2.3.1. It is noted that such sensory deprivation can produce and aggravate confusional and disorientated states.

4.3. At the beginning of 1998, she had become increasingly forgetful and less able physically but was inclined to wander and she had about a six months' history of falls.

4.4. On 29th July 1998, at the Glen Heathers Nursing Home, Mrs RICHARDS developed a fracture of the neck of her right femur [thighbone] and she was transferred to the Royal Hospital Haslar, Gosport.

4.4.1. In the Accident & Emergency department she was given 2.5mg of **morphine** and 50 mg of **cyclizine** at 2300 hours to relieve her pain and distress. She was known to be taking **haloperidol** 1mg twice daily and **Tradazone** 100mg at night.

4.5. On 30th July 1998 Mrs RICHARDS had a right cemented hemiarthroplasty [an artificial hip joint inserted].

4.5.1. Post-operatively she was given 2.5 mg morphine intravenously on July 30th at 0230 hours, 31st at 0150 and 1905 hours, and on August 1st at 1920 hours and 2nd at 0720 hours. From August 1st –7th she was weaned over to two tablets of **co-codamol**, requiring these on average twice daily for pain relief.

4.5.2. On 3rd August 1998 it was noted 'All well. Sitting out early mobilization'.

4.6. On 5th August 1998, Dr REID, a consultant geriatrician, saw her. He stated in a letter that '... she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport Memorial Hospital.'

4.6.1. Dr REID also noted that Mrs RICHARDS had continued on Haloperidol and '... her Trazodone has been omitted. According to her daughters it would seem that since her Tradozone has been omitted she has been much brighter mentally and has been speaking to them at times.'

4.7. A discharge letter, dated 10th August 1998, was sent by the sergeant staff nurse at the Royal Hospital Haslar and addressed to 'The Sister in Charge Ward [sic] Memorial Hospital, Bury Road, Gosport, Hants.' It contained the following information:-

4.7.1. After the operation Mrs RICHARDS became '...fully weight bearing, walking with the aid of two nurses and a **Zimmer frame**.' She was noted to require 'total care with washing and dressing, eating and drinking....' She was '... continent, when she become[s] fidgety and agitated it means she wants the toilet....' She 'Occasionally says recognisable words, but not very often.' Her wound 'Is healed, clean and and dry.'

4.8. On 11th August 1998, Mrs RICHARDS was transferred to Daedalus ward at the Gosport War Memorial Hospital. She was not in pain and had been fully weight bearing at the Royal Hospital Haslar walking with the aid of two nurses and a Zimmer frame.

4.8.1. At the Gosport War Memorial Hospital there was an unsigned 'Summary' record which is apparently a Nursing record and this states:-

4.8.1.1. '11-8-98 Addmitted [sic] from E6 Ward Royal Hospital Haslar, into a continuing care bed. Gladys had sustained a right fractured neck of Femur on 30th July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a Zimmer frame. Daughter visits regularly and feeds mother. She wishes to be informed Day or night of any deterioration in mothers condition....'

4.8.2. The contiguous 'Assessment Sheet' states, 'Patient has no apparent understanding of her circumstances due to her impaired mental condition ... Deaf in both ears ... Cataract operation to both eyes ... occasionally says recognisable words, but not very often ... soft diet. Enjoys a cup of tea ... requires feeding ... Dental/Oral status Full "Set" – keeps teeth in at night.'

4.8.3. The 'Patient Medication Information' states, '11.8.98 ... Haloperidol O[rally] 1 mcg [looks like 'mcg' but probably is 'mg' since this drug is not prescribed in single **microgram** doses] B.D. [twice daily]'

4.9. ??[initials]B [subsequently identified as Dr BARTON] has written in the medical case records '11-8-98 Transferred to Daedalus Ward Continuing Care.... O/E [on examination] Impression frail demented lady [paragraph] not obviously in pain [paragraph] Please make comfortable [paragraph] transfers with hoist Usually continent needs help with **ADL [activities of daily living]**.... I am happy for nursing staff to confirm death.'

4.10. At 1300 hours on the 13th August 1998 the Nursing Contact Record states 'Found on floor at 13.30hrs [sic]. Checked for injury none apparent at time hoisted into safer chair 20.00 [hours][altered on record to 19.30] pain Rt [right] hip internally rotated. Dr BRIGG contacted advised Xray AM [in the morning] & **analgesia** during the night. Inappropriate to transfer for Xray this PM [evening] [initialled signature (? by whom)] RGN [Registered General Nurse] [next line] Daughter informed.'

4.11. Dr BARTON has recorded '14-8-98 Sedation/pain relief has been a problem screaming not controlled by haloperidol 1 [illegible symbol or word] but very sensitive to **oramorph**. Fell out of chair last night ... Is this lady well enough for another surgical procedure?'

4.12. In her contiguous note Dr BARTON has recorded '14-8-98 Dear [?] Cdr [Commander] SPALDING Further to our telephone conversation thank you for taking this unfortunate lady who slipped from her chair at 1.30 pm yesterday and appears to have dislocated her R[ight] hip.... She has had 2.5ml of 10mg/5ml Oramorph at midday.'

4.12.1. According to the letter signed by Philip BEED, Mrs RICHARDS was given 10mgs of Oramorph at 1150 hours on 14th August 1998 prior to being transferred back to the Royal Hospital Haslar.

4.13. The Nursing Contact Record at Daedalus ward continues:-

4.13.1. '14/8/98 am [morning] R[ight] Hip Xrayed – Dislocated [paragraph] Daughter seen by Dr BARTON & informed of situation. For transfer to Haslar A&E [accident and emergency department] for reduction under sedation [initialled signature]'

4.13.2. 'pm [afternoon or evening of 14th August 1998] Notified that dislocation has been reduced. [Mrs RICHARDS] To stay in Haslar [hospital] for 48 hours then return to us [[initialled signature] Family aware.'

4.14. At the Royal Hospital Haslar (at 1400 hours) Xray having confirmed that the hemiarthroplasty had dislocated, intravenous sedation using 2 mgs of midazolam

25

allowed the dislocation to be corrected by traction. The procedure was described as 'Under sedation c [with] CVS/RS [cardiovascular and respiratory systems] monitoring. ... Easy reduction.' Mrs RICHARDS was noted to be 'rather unresponsive following the sedation. The [She] gradually became more responsive....' She was then admitted the Royal Hospital for 48 hours observation.

4.15. Apart from two tablets of co-codamol on the 15th August 1998, she did not need to be given any pain relief following the reduction of her hip dislocation.

4.15.1. Two days later, on 17th August 1998, it was recorded that 'She was fit for discharge that day and she was to remain in straight knee splint for four weeks. In the discharge letter from Haslar Hospital it was also recorded that Mrs RICHARDS was to return to Daedalus Ward. It was further stated that 'She has been given a canvas immobilising splint to discourage any further dislocation, and this must stay in situ for four weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing.'

4.16. On 17th August 1998 it was also recorded that she was 'Fit for discharge today (Gos[port] War Mem[orial hospital). To remain in straight knee splint for 4/52 [four weeks] ... No follow-up unless complications.'

4.17. She was returned to Daedalus ward in the Gosport War Memorial Hospital later that day but in a very distressed state. The Daedalus ward nursing record states 'Returned from R.N. Haslar, patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew To remain in straight knee splint for 4/52 [four weeks] For pillow between legs at night (abduction) No follow-up unless complications.'

4.17.1. Mrs RICHARDS was given Oramorph 2.5 mg in 5mls. The nursing record for 17th August 1998 further states '1305 [hours] ... Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an Xray. M. COUCHMAN. [paragraph] pm Hip Xrayed at 1545 [hours] Films seen by Dr PETERS & radiologist & no dislocation seen. For pain control overnight & review by Dr BARTON mane [in the morning]. ?[illegible nurse signature]

4.17.1.1. This radiograph was reported by Dr. DOMJAN, Consultant Radiologist as showing 'RIGHT HIP: The right hemiarthroplasty is relocated in the **acetabulum**.'

4.18. On 17th August 1998, Dr BARTON noted 'Readmission to Daedalus from RHH [Royal Hospital Haslar] Closed reduction under iv [intravenous] sedation remained unresponsive for some hours now appears peaceful. Plan Continue haloperidol [paragraph] Only give oramorph if in severe pain See daughter again.'

4.19. On 18th August 1998, Dr BARTON recorded 'Still in great pain [paragraph] Nursing a problem. [paragraph] I suggest sc[subcutaneous] diamorphine/Haloperidol/midazolam [paragraph] I will see daughters today [paragraph] please make comfortable.'

4.20. The nursing Contact Record on Daedalus ward in the Gosport War Memorial Hospital continues:-

4.20.1. '18/8/98 am Reviewed by Dr Barton. For pain control via syringe driver. [paragraph] 1115 Treatment discussed with both daughters [Mrs LACK and Mrs MACKENZIE]. They agree to use of **syringe driver** to control pain [It is noted that Mrs LACK has disagreed with this statement] & allow nursing care to be given. [paragraph] 1145 Syringe driver diamorphine 40 mg. Haloperidol 5 mg, Medazolam [midazolam] 20 mg commenced'

4.20.2. '18/8/98 20.00 Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs. [paragraph] Daughter quite upset and angry about mother's condition, but appears happy that she is pain free at present. C JOICE.'

4.20.2.1. It is noted that a 'disturbance reaction' occurs in patients when they are moved that is easily mistaken for pain requiring specific treatment. It is noted here that Mrs RICHARDS was described as being 'pain free' at this time apart from when she was being moved.

4.20.3. The nursing Contact Record continues 'Daughter, Jill, stayed the night with Gladys [Mrs RICHARDS], grandson arrived in early hours of morning [initialled signature; dated '19/8/98'] [paragraph] He would like to discuss Grand mother's condition with someone – either Dr. Barton or Phillip Beed later today [initialled signature]' [paragraph] '19/8/98 am Mrs Richards comfortable. [paragraph] Daughters seen. Unhappy with various aspects of care, complain[t] to be handled officially by Mrs S Hutchings Nursing co-ordinator [initialled signature]'

4.20.4. It is noted that there is no continuing nursing Contact Record for the 20th August 1998.

4.20.5. The contiguous nursing Contact Record states '21/8/98 12.13 [hours] Patient's [Mrs RICHARDS] overall condition deteriorating, medication keeping her comfortable. Daughters visited during the morning. C JOICE'

4.21. Dr BARTON's next contiguous medical record was on 21st August 1998 when she wrote 'Much more peaceful [paragraph] needs Hyoscine for rattly chest'.

4.21.1. It is noted that Mrs RICHARDS was already being given hyoscine at this time and had been doing so continuously since 19th August 1998.

4.21.2. Nurse GRIFFIN made the next note in the medical records on 21st August 1998 stating that Mrs Richards was dead at 2120 hours.

4.22. The Nursing Care Plan records state:-

4.22.1. '12.8.98 Requires assistance to settle and sleep at night.... 12.8.98 Haloperidol given at 2330 [hours] as woke from sleep very agitated shaking and crying. Didn't settle for more than a few minutes at a time. Did not seem to be in pain.'

4.22.2. '13.8.98 oromorph at 2100 [hours] Slept well [initialled signature] [paragraph] For Xray tomorrow morning [initialled signature]'

4.22.3. '14.8.98 Same pain in rt[right] leg / ?[query] hip this am. [initialled signature]'

4.22.4. 'Re-admitted 17/8/98'

4.22.5. '17.8.98 Oromorph [Oramorph] 10mg/5ml at present.'

4.22.6. '18.8.98 Now has a syringe driver with 40mgs Diamorphine – comfortable. Daughters stayed. [initialled signature]'

4.22.7. 'Daughters stayed with Gladys [Mrs RICHARDS] overnight. [initialled signature]'

4.22.8. There is no record of continuance of the Nursing Care Plan for 20th and 21st August 1998.

4.22.9. After Mrs RICHARDS had been readmitted to Daedalus ward on 17th August 1998, there is no record between 17th and 21st August 1998 in the patient Nursing Care Plan for 'Nutrition'. On 21st August the record states 'no food taken [initialled signature]'.

4.22.9.1. There is no record that Mrs RICHARDS was offered any fluids.

4.22.10. Similarly, the Nursing Care Plan for 'Constipation' shows no record between 17th and 21st August1998. On 21st August the record states 'BNO [bowels not open] [initialled signature]'

4.22.11. The Nursing Care Plan for 'Personal Hygiene' states:-

4.22.11.1. '18.8.98 Complete Bed Bath given plus oral [Signature] Hygiene [second signature]'

4.22.11.2. '18.8.98 Night: oral care given frequently'

4.22.11.3. '19.8.98 Nightie changed & washed, repositioned. Apparently pain free during care [initialled signature]'

4.22.11.4. It is noted that there is no record of Mrs Richards being attended to for 'Personal Hygiene' on 20th August 1998.

4.22.11.5. '21.9.98 General care and oral hygiene given [initialled signature]'

4.23. The drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital from the time of her admission there on 11th August 1998 are described below.

Drugs prescribed for Mrs RICHARDS at Gosport War Memorial Hospital

5. Dr BARTON wrote the following drug prescriptions for Mrs RICHARDS.

5.1. On 11th August 1998:-

5.1.1. Oramorph 10mgs in 5mls to be given orally four hourly. On the Administration Record these doses are recorded as being given—

5.1.1.1. twice on 11th August 1998 (10mg at 1015 [?1215] and 10mg at 1145 [?pm]);

5.1.1.2. once on 12th August (10mg at 0615);

5.1.1.3. once on 13th August (10mg at 2050);

5.1.1.4. once on 14th August (5ml [10mg] at 1150);

5.1.1.5. four times on 17th August (2.5ml [5mg] at 1300, 2.5ml [5mg] at ????[time illegible], 2.5ml [5mg] at1645, and 5ml [10mg] at 2030); and,

5.1.1.6. twice on 18th August 1998 5ml [10mg] at 01230[sic and ? meaning 0030 hours] and 5ml [10mg] at [?]0415).

5.1.2. Diamorphine at a dose range of 20 – 200 mg to be given subcutaneously in 24 hours.

5.1.2.1. None of this diamorphine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.3. Hyoscine at a dose range of 200 – 800 mcg [micrograms] to be given subcutaneously in 24 hours.

5.1.3.1. None of this hyoscine prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.4. Midazolam at a dose range of 20-80 mgs to be given subcutaneously in 24 hours.

5.1.4.1. None of this midazolam prescription is recorded on the Administration Record as having been given between 11th – 14th August inclusive.

5.1.5. Haloperidol 1mg orally twice daily. It is noted that at the top of this prescription chart 'TAKES MEDICINE OFF A SPOON' [sic] is clearly written.

5.1.5.1. She was give 1mg of haloperidol at 1800 hours on 11th August 1998, at 0800 and 2330 hours on 12th August 1998, at 0800 and 1800 hours on 13th August 1998.

5.1.5.2. In addition, on 13th August 1998, Mrs RICHARDS was prescribed haloperidol 2mgs in 1ml to be administered orally as required at a dose of 2.5ml [this figure has been altered and also can be read as 0.5 ml] to be given 'IF NOISY' [sic]. She was given a dose [quantity not stated bearing in mind the altered prescription] at 1300 on 13th August 1998.

5.1.5.3. She was also given 1mg of haloperidol at 0800 hours on 14th and also at 1800 hours on 17 August 1998.

5.1.6. It is noted that, apart from 2330 hours on 12 August 1998, at the above times when Mrs RICHARDS was given haloperidol she was also give 10ml of **Lactulose** [a purgative].

5.2. On 12th August 1998:-

5.2.1. Oramorph 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly [equivalent to 5mgs of oramorph].

5.2.1.1. Although this drug was apparently not administered its prescription was written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

5.2.2. Oramorph 10mgs in 5mls to be given orally once at night.

5.2.2.1. Although this drug was apparently not administered its prescription was also written up on the 'Regular Prescription' chart but at the side in an ink-drawn box there are the letters PRN [meaning that the prescription is to be administered as required].

5.3. 18th August 1998:-

5.3.1. Diamorphine at a dose range of 40-200mg to be administered subcutaneously in 24 hours

5.3.2. Haloperidol a dose range of 5-10 mgs to be administered subcutaneously in 24 hours.

5.4. On 18th, 19th, 20th, and 21st August 1998, Mrs RICHARDS was given simultaneously and continuously subcutaneously diamorphine 40mgs, and haloperidol 5mgs, and midazolam 20mgs during each 24 hours.

5.4.1. These drugs are recorded as being administered at the same time of day on each of the four days they were given. They were administered at 1145, 1120, 1045, and 1155 for 18th, 19th, 20th, and 21st August 1998 respectively.

5.4.1.1. All these drugs were administered at the times stated and were signed off by initials as being co-administered by the same person each day. Over the four days of 18th, 19th, 20th, and 21st August 1998, at least three nurses were involved in administering these drugs.

5.4.1.2. According to the prescription charts these drugs were signed for as being administered to Mrs RICHARDS via the syringe driver by Mr Philip BEED on 18th and 19th August 1998, by Ms Margaret COUCHMAN on 20th August 1998, and by Ms Christine JOICE on 21st August 1998.

5.4.2. It is noted that on the 19th, 20th, and 21st August 1998 the drugs midazolam 20mgs, diamorphine 40mgs, and haloperidol 5mgs were also co-administered subcutaneously in 24 hours with 400mcg of hyoscine [this last drug had been

prescribed by Dr BARTON to be given as required on 11th August 1998 but its administration was not commenced until 19th August 1998].

5.4.3. It is also noted that all the drugs for subcutaneous administration were not prescribed at specific starting dosages but each was prescribed for a wide range of dosages and for continuous administration over 24-hour periods.

5.4.3.1. It is not known who selected the dosages to be given.

Death certification and cremation

6. The circumstances of Mrs RICHARDS death have been recorded as follows:

6.1. In a document [Case no. 1630/98] initialled by the Coroner on 24th August 1998 'Reported by Dr BARTON [sic]. Deceased had undergone surgery for a fractured neck of femur. Repaired. Death cert[ificate] issued. [paragraph] THOMAS [sic]

6.2. The cause of death was accepted by the Coroner on 24th August 1998 as being due to:-

6.2.1. '1(a) Bronchopneumonia'.

6.2.2. The death was certified as such by Dr J A BARTON and registered on 24th August 1998.

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

6.3. The body was cremated.

Conclusions

7. Mrs Gladys Mable RICHARDS died on 21st August 1998 while receiving treatment on Daedalus ward at Gosport War Memorial Hospital.

7.1. Some fours years earlier, on 5th August 1994, Mrs RICHARDS had become resident at the Glen Heathers Nursing Home.

7.2. Mrs RICHARDS's 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.

7.3. On 29th July 1998, Mrs RICHARDS 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.

7.4. Despite her confused state, Mrs RICHARDS was considered by medical staff at the Royal Hospital Haslar to be suitable for implantation of an artificial hip joint. This took place on 30th July 1998.

7.5. 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.

7.6. At that time Dr BARTON recorded that Mrs RICHARDS was not obviously in pain but despite this Dr BARTON prescribed Oramorph [an oral morphine preparation] to be administered orally four hourly.

7.6.1. At that time also Dr BARTON prescribed for Mrs RICHARDS diamorphine, hyoscine, and midazolam. These drugs were to be given subcutaneously and continuously over periods of 24 hours for an undetermined number of days and the exact dosages were to be selected from wide dose ranges.

7.6.2. Also on 11th August 1998, at the end of a short case note, Dr BARTON wrote 'I am happy for nursing staff to confirm death'.

7.6.3. 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 midazolam) were not administered at that time.

7.7. On 13th August 1998, Mrs RICHARDS's artificial hip joint became dislocated.

7.8. The following day, 14th August 1998, although Dr BARTON had recorded 'Is this lady well enough for another surgical procedure?' she arranged for Mrs RICHARDS to be transferred back to Haslar Hospital where the dislocation of the hip was reduced.

7.8.1. It is noted that at the age of 91 years, and despite Dr Barton's comment about Mrs RICHARDS, and her confused mental state, Mrs RICHARDS was considered well enough by the staff at the Royal Hospital Haslar to have two operations on her right hip within about two weeks.

7.9. Three days later, on 17th August 1998, Mrs RICHARDS was returned to the Gosport War Memorial Hospital on a sheet and not on a stretcher. She was very distressed when she reached Daedalus ward.

7.10. There is no evidence that Mrs RICHARDS, 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.

7.11. Despite this, and on 18th August 1998, Dr BARTON, while knowing of Mrs RICHARDS's sensitivity to oral morphine and midazolam, prescribed diamorphine, midazolam, haloperidol, and hyoscine to be given (from wide dosages ranges) continuously subcutaneously and by a syringe driver over periods of 24 hours for an unlimited period.

7.11.1. Neither midazolam nor haloperidol is licensed for subcutaneous administration.

7.11.2. 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.

7.11.3. It is also noted that Mrs RICHARDS was not receiving treatment for cancer.

7.12. There is no evidence that in fulfilling her duty of care Dr BARTON reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.

7.13. During this period when a syringe driver was being used to administer the subcutaneous drugs, there is no evidence that Mrs RICHARDS was given fluids or food in any appropriate manner.

7.14. There is no evidence that in fulfilling their duty of care Mr Philip BEED, Ms Margaret COUCHMAN and Ms Christine JOICE reviewed appropriately Mrs RICHARDS's clinical condition from 18th August 1998 to determine if any reduction in the drug treatment they were administering was indicated.

7.15. There is, however, indisputable evidence that the subcutaneous administration of drugs by syringe driver continued without modification and during every 24 hours from 18th August 1998 until Mrs RICHARDS died on 21st August 1998.

7.16. Dr Barton recorded that death was due to bronchopneumonia.

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

My opinion

8. When Mrs RICHARDS was first admitted to Daedalus ward at Gosport War Memorial hospital on 11th August 1998 she was not in pain and had been fully weight bearing walking with the aid of two nurses and a Zimmer frame.

8.1. Despite recording that Mrs RICHARDS was not in pain, on 11th August 1998 Dr BARTON prescribed wide dosage ranges of opiate and sedative drugs to which Mrs RICHARDS was known to be sensitive.

8.1.1. Dr Barton also recorded that 'I am happy for nursing staff to confirm death.' when Mrs RICHARDS had been admitted for rehabilitation and her death was not obviously imminent.

8.2. When, at the age of 91 years, Mrs RICHARDS dislocated her operated hip and despite her confused mental state, she was considered well enough to have a second operation on her right hip within about two weeks of the first operation.

8.3. There is no evidence to show that after her second operation Mrs RICHARDS, 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.

8.4. It is my opinion, and there is evidence to show, that Mrs RICHARDS was capable of receiving oral medication for the relief of the pain she was experiencing on 17th August 1998.

8.5. Mrs RICHARDS was known by Dr BARTON to be very sensitive to Oramorph, an oral morphine preparation, and to have had a prolonged sedated response to intravenous midazolam.

8.6. Despite this, and from 18th August 1998 for an undetermined and unlimited number of days, Dr BARTON prescription led over 24-hours periods to the continuous subcutaneous administration to Mrs RICHARDS of diamorphine 40mgs, haloperidol 5mgs, and midazolam 20mgs to which was added hyoscine 400mcg from 19th August 1998.

8.7. The administration of these drugs continued on a 24-hours regime without their dosages being modified according to Mrs RICHARDS's response to them and until Mrs RICHARDS died on 21st August 1998.

8.8. There is no record that Mrs RICHARDS was given any food or fluids to sustain her from the 18th August 1998 until she died on 21st August 1998.

8.9. As a result of the continuous subcutaneous administration of the prescribed drugs diamorphine, haloperidol, midazolam, and hyoscine Mrs RICHARDS became unconsciousness and died on 21st August 1998.

8.10. No other event occurred to break the chain of causation and in my opinion Mrs RICHARDS's death was directly attributable to the administration of the drugs she continuously received by syringe driver from 18th August 1998 until her death on 21st August 1998.

8.11. It is my opinion that Mrs Gladys RICHARDS's death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine, haloperidol, midazolam, and hyoscine which had been prescribed to be administered continuously by a syringe driver for an undetermined number of days.

APPENDIX A

14. I have received and read the following documents:-

14.1. The letter of DCI BURT dated 22nd November 1999 that gave an initial overview of the case.

14.2. The documents in the file DCI BURT presented at our meeting on 28th January 2000 as follows:-

14.2.1. 1) Draft (unsigned) statement (MG11) of Lesley HUMPHREY.
14.2.2. 2) Copy of PEC (NHS) T Health Record (LH/1/C).
14.2.3. 3) Copy of RHH Medical Record (AF/1/C).
14.2.4. 4) Draft (unsigned) statement (MG11) of Gillian MACKENZIE.
14.2.5. 5) Draft (unsigned) statement of Lesley LACK.

14.3. The documents in the file DCI BURT presented at our meeting on 8th March 2000 including those pursuant to my request of 28th January 2000 (documents WX1, WX2, and YZ were forward to me on 9 March 2000) as follows:-

14.3.1. A Typed copy of Notes prepared by Mrs LACK and given to Portsmouth Healthcare NHS Trust
14.3.2. B Typed copy of additional page of notes which was prepared by Mrs LACK but, apparently, not passed to Portsmouth Healthcare NHS Trust
14.3.3. C Typed copy of Notes prepared by Mrs LACK and given to Social Services
14.3.4. D Typed copy of comments made by Mrs LACK in respect of letter from Portsmouth Healthcare NHS Trust which represented a response to her Notes of complaint (A)

14.3.5.	E	Typed copy of comments made by Mrs LACK in respect of a Report prepared by Portsmouth Healthcare NHS Trust which resulted in the letter referred to above
14.3.6.	F	As D above but made by Mrs MACKENZIE
14.3.7.	G	As E above but made by Mrs MACKENZIE
14.3.8.	HI	Copy of letter written by Mrs MACKENZIE to DI MORGAN (OIC of initial investigation) plus 5 copies newspaper cuttings
14.3.9.	JK	Copy of Coroner's Officer's Form
14.3.10.	L	Copy of letter from Dr REID to S/Cdr SCOTT
14.3.11.	M	Copy of Report made by Dr LORD during original investigation
14.3.12.	N	Copy of additional newspaper cutting
14.3.13.	O (1)	Typed copy of signed statement of Anne FUNNELL (RHH)
14.3.14.	O (2)	Typed copy of signed statement of Lesley HUMPHREY (Portsmouth Healthcare NHS Trust)
14.3.15.	O (3)	Copy of signed statement of Lesley LACK
14.3.16.	O (4)	Copy of final draft of Gillian MACKENZIE's statement
14.3.17.	PQ	Copy of schedule of x-ray images (RHH)
14.3.18.	R	Copy of Risk Event Record (Portsmouth Healthcare NHS Trust)
14.3.19.	S (1)	Copy of letter which DCI BURT has sent to Lesley HUMPHREY (Portsmouth Healthcare NHS Trust) raising various issues
14.3.20.	S (2)	Copy of entries in medical directories 1998/1999 - Dr Jane Ann BARTON
14.3.21.	S (3)	Copy of letter from Mrs MACKENZIE to DCI BURT
14.3.22.	S (4)	Copy of documents which accompanied the two Portsmouth Healthcare NHS Trust x-ray images
14.3.23.	T	Copy of various documents which featured in a Social Services Case Conference stemming from receipt of Mrs LACK's Notes of complaint (C above)
14.3.24.	UV	Copy of Death Certificate - Mrs RICHARDS
14.3.25.	WX1	Witness Statement of Mrs Gillian MACKENZIE dated March 6 2000
14.3.26.	WX2	Copy of letter from DR J.H. BASSETT to Mrs MACKENZIE with an addendum of five pages being a photocopy from 'Toxic Psychiatry' a book by Dr Peter BREGGEN published by Harper Collins.
14.3.27.	YZ	Two extracts from 'Criminal Law. Diana Rowe. Hodder & Stoughton 1999.'

14.4. On 8th March 2000, in the presence of DCI BURT, I visited:-

14.4.1. the Gosport Memorial Hospital and followed the passageways along which Mrs Richards was conveyed and the ward areas in which she was treated; and,

14.4.2. the Royal Hospital Haslar and followed the passageways along which Mrs Richards was conveyed and the ward area in which she was treated.

14.4.2.1. At the Royal Hospital Haslar, on 8th March 2000, in the presence of DCI BURT, I was also shown twelve (12) radiographs relating to Mrs Richards' treatment there on 12th April 1998, 17th July 1998, 14th August 1998, 29th July 1998, and 31st July 1998.

14.5. In addition I have read the following the documents given to me by DCI BURT on 12th May 2000 consisting of the following which are numbered below as listed in the two containing ring binders:

14.5.1.	E 25	Copy of Glen Care Homes file Re: Gladys RICHARDS supplied by Glen Care Homes
14.5.2.	E 22	Copy of Hampshire County Council Social Services file Re: Gladys RICHARDS
14.5.3.	E23	Copy of Glen Care Homes file Re: Gladys RICHARDS supplied Nursing Homes Inspectorate
14.5.4.	E 24	Copy Portsmouth and South East Hampshire Health Authority GP Patient Records of Gladys RICHARDS
14.5.5.	D 63	Police letter 090300 to Miss CROSS, Haslar Hospital with further questions
14.5.6.	D 65	Letter 100400 from Miss CROSS at Haslar including Patient transfer order and further medical records
14.5.7.	D 104	Letter 080200 from Mrs. MACKENZIE with notes Re: draft statement
14.5.8.	D 108	Portsmouth NHS Trust Dept. of Diagnostic Imaging report folder
14.5.9.	D 110	Copy typed Gladys RICHARDS Death Certificate dated 240898

14.6. I have also read the documents given to me by DCI BURT on 19th July 2000, consisting of copies of the statements made by:-

14.6.1. JOICE Christine
14.6.2. GIFFIN Sylvia Roberta
14.6.3. PULFORD Monica Catherine
14.6.4. WALKER Fiona Lorraine
14.6.5. MARJORAM Catherine
14.6.6. BALDACCHINO Linda Mary
14.6.7. PERKINS Margaret Joan
14.6.8. TUBBRITT Anita
14.6.9. COUCHMAN Margaret
14.6.10. WALLINGTON Kathleen Mary
14.6.11. FLETCHER Anne
14.6.12. COOK Joanne
14.6.13. MOSS JEAN Kathleen
14.6.14. TYLER Christina Ann

14.7. I have also read statements, provided on 30th August 2000 by DCI BURT, made by:

14.7.1. Doctor Jane Ann BARTON
14.7.2. Phillip James BEED

14.8. I have also received from DCI BURT on 8th September 2000 and read copies of:-

14.8.1. A letter dated 18th August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.8.1.1. Enclosed with this letter was a copy of a letter dated 9th August 2000 from Ms Jill BAKER to Mrs Gillian MACKENZIE to which had been added a petition form.

14.9. A letter dated 21st August 2000 from Mrs Gillian MACKENZIE to DCI BURT.

14.9.1. Enclosed with this letter was a copy of a letter dated 14th December 1998 from Ms Lesley HUMPHREY, Quality Manager at Portsmouth Healthcare NHS Trust Central Office to Mrs Gillian MACKENZIE. This had enclosed with it a copy of a letter dated 22nd September 1998 from Mr Max MILLETT, Chief Executive of Portsmouth Healthcare NHS Trust.

14.10. Copies of Witness Statements (taken by Mrs S HUTCHINGS who led the initial Internal Inquiry as Investigating Officer of Portsmouth Healthcare NHS Trust) as follows:-

14.10.1. On 3rd September 1998 statement consisting of four pages from Mrs Jenny BREWER – Staff Nurse Daedalus Ward to which is attached an additional statement (three pages) by Staff Nurse Brewer (the first page of this three pages is headed Portsmouth Healthcare NHS Trust and has been signed on page three by S. N J Brewer RGN and dated 9-9-98 (Reference D142)).

14.10.2. On 8th September 1998 statement consisting of five pages from Mr Philip BEED – Clinical Manager Daedalus Ward (Reference D143).

14.10.3. On 9th September 1998 statement consisting of three pages from Ms Christine JOICE – Staff Nurse Daedalus Ward (Reference D144).

14.10.4. On 8th September 1998 statement consisting of two pages from Ms Monica PULFORD – Enrolled Nurse Daedalus Ward (Reference D145).

14.10.5. On 3rd September 1998 statement consisting of four pages from Ms Margaret COUCHMAN – Staff Nurse Daedalus Ward (Reference D146).

14.11. A copy of the National Council for Hospice and Specialist Palliative Care Services paper entitled 'Ethical decision-making in palliative care'.

14.12. On 5th and 6th October 2000 I received from Hampshire Constabulary and subsequently read:-

14.12.1. The records of the interviews conducted with Dr Anthea Everista Geredith LORD on 27th September 2000.

14.12.2. During these interviews Dr LORD produced as listed in the Officer's Report by DC McNally the following documents:-

14.12.2.1. Drug Therapy Guidelines for subcutaneous fluid replacement as approved by the Elderly Medicine and Formulary & Medicines Group of Portsmouth Hospitals and Portsmouth Healthcare updated for 1998.

14.12.2.2. Consultants' Rota for August 1998 of the Department of Medicine for Elderly People (Ref: CI/28.7.98).

14.12.2.3. Memorandum from Mrs. L HUMPHREY of Portsmouth Health Care NHS Trust to Dr. LORD dated 17th December 1998 and headed 'Mrs. Richards deceased, Gosport War Memorial Hospital, 21st August, 1998.'

14.12.2.4. Letter from Dr R I REID, Medical Director of Portsmouth Health Care NHS Trust giving approval of study leave for Dr. LORD for the dates of 17/18 August 1998.

14.12.2.5. Consultants' Timetable of the Department of Medicine for Elderly People from 4.5.98 – 8.2.99.

Appendix B

Facts of the environment - obtained from the statements of Mrs RICHARDS's daughters

15. Mrs MACKENZIE is the elder of Mrs RICHARDS's two daughters. It is noted that her sister, Mrs LACK, is a retired Registered General Nurse.

15.1. Mrs LACK retired in 1996 after 41 years continuously in the nursing profession. For 25 years prior to retirement she was involved in the care of elderly people. For 20 years prior to retiring she held supervisory and managerial positions in this field of nursing.

15.2. By July 1998, Mrs RICHARDS had been resident at the Glen Heathers Nursing Home for some four years. She had a past medical history of bilateral deafness for which she required two hearing aids (unfortunately these were lost while she was at the Glen Heathers Nursing Home). She had had operations for the removal of cataracts and required glasses (unfortunately these were also lost at the Glen Heathers Nursing Home).

15.3. Also by July 1998, Mrs RICHARDS had become increasingly forgetful and less able physically. She had had 17 falls documented at the Glen Heathers Nursing Home between 29th January 1998 and 29th July 1998.

15.3.1. During this period Mrs MACKENZIE decided to meet and question her mother's general practitioner, Dr BASSETT. Mrs MACKENZIE had formed the opinion that the drugs Dr BASSETT was prescribing could contribute to her mother's confused mental state and deterioration of her physical health. One drug was Trazodone and the other was haloperidol. Following this meeting she sent him a copy of a book entitled *Toxic Psychiatry*.

15.3.2. Dr BASSETT replied, in a hand-written letter, thanking Mrs MACKENZIE and stating '... I have a reputation in Lee [-on-Solent] of being somewhat sparing with 'mood' drugs and especially antibiotics. ... most drugs are prescribed with more caution these days. [paragraph] Hopefully we can continue to keep your Mother's drugs to a minimum!'

15.4. It is convenient to mention here that both Mrs MACKENZIE and Mrs LACK have registered serious concerns about the care given to their mother in the Glen Heathers Nursing Home.

15.4.1. Jane PAGE, Principal Nursing Home Inspector, Portsmouth & S.E. Hants Health Authority investigated these concerns formally. On 11th August 1998, she made an unannounced visit to the Glen Heathers Nursing Home. She reported, on 26th August 1998, that 'From the written records obtained and discussions held, I can find no evidence to substantiate that Mrs RICHARDS did not receive appropriate care and medication.'

15.4.2. These concerns were discussed further by the Social Services Department at a meeting held on 23rd November 1998 when Mrs LACK was present. The conclusion was that 'There was no evidence of deliberate abuse [of Mrs RICHARDS] although there seemed to be problems of complacency in some of the care practices which needed review.... However, there was no evidence of malpractice by the Home.'

15.5. On 29th July 1998, while in the Glen Heathers Nursing Home, Mrs RICHARDS sustained a fracture of the neck of her right femur (thighbone). According to Mrs

LACK her mother underwent a surgical operation on 30th July 1998 'following a discussion with the consultant who thought my mother should be given the chance to remain ambulant.'

15.6. Mrs LACK has also stated:-

15.6.1. 'My mother received a replacement hip, on her right side, and remained in the Haslar Hospital a further eleven days until Tuesday the 11th August 1998. [paragraph] I visited my mother every day during this period and, in my view, when taking into account the serious injury which she had sustained and the trauma she had suffered, my mother appeared to make a good recovery during this period.'

15.6.2. 'Prior to her discharge, and transfer to the Gosport War Memorial Hospital, my mother was responding to physiotherapy, able to walk a short distance with the aid of a zimmer frame and no longer required a catheter. Her medication had been reduced and she was able to recognise family members and make comments to us which made sense.'

15.6.3. 'She was with encouragement, eating and drinking naturally and as a result the drips, which had facilitated the provision of nourishment after the operation, had been removed.'

15.6.4. 'Significantly, my mother was no longer in need of pain relief. It was quite apparent, to me, that she was free of pain.'

15.6.5. 'Such was the extent of my mother's recovery that it was considered appropriate to discharge her and transfer her to the Gosport War Memorial Hospital where she was admitted to Daedalus Ward on Tuesday the 11th August 1998. This was the first occasion that my mother had been admitted to this particular hospital.'

15.7. On 12th August 1998, the day after her mother's admission to the Gosport War Memorial Hospital, Mrs LACK visited her mother there and has recorded '... I was rather surprised to discover that I could not rouse her [Mrs RICHARDS]. As she was unrousable she could not take nourishment or be kept hydrated. [paragraph] I enquired among the staff and I was told that my mother had been given the morphine based drug 'Oramorph' for pain. This also surprised me. When my mother had been discharged from the Haslar Hospital, the day before, she had not required pain relief for several days. [paragraph] I was distressed to observe my mother's deteriorated condition which significantly contrasted with the level of recovery which had been achieved following treatment at the Haslar hospital during the period after the surgical operation to replace her hip. [paragraph] I was told that my mother had been calling out, showing signs of being anxious, and it was believed that she was suffering pain. They did not investigate the possible cause. I consider it likely that she was in need of the toilet. ... One of the

consequences of being rendered unrousable, by the effects of 'Oramorph', was that no fluids could be given to my mother and this, together with the abandonment of other forms of rehabilitation, would have served to inhibit or prevent the recovery process which had begun prior to her admission to the Gosport War Memorial Hospital.'

15.8. Mrs RICHARDS had a fall on 13th August 1998 (as described above). On the following morning (14th August 1998), Mrs LACK noted that while her mother was being taken to the X-ray department at the Gosport War Memorial Hospital 'She was still deeply under the effects of the 'Oramorph' drug.'

15.9. As described above Mrs RICHARDS was then transferred to the Royal Hospital Haslar for the reduction of her dislocated artificial hip. She was returned to the Gosport War Memorial Hospital on 17th August 1998 having been noted the previous day (16th August) by Mrs LACK [a nurse experienced in the care of elderly people] to be 'easily manageable'.

15.9.1. In accepting that he would transfer Mrs RICHARDS to the Gosport War Memorial Hospital, Dr REID (consultant geriatrician) had stated that '... despite her dementia, she [Mrs RICHARDS] should be given the opportunity to try to re-mobilise.'

15.10. On visiting her mother at the Gosport War Memorial Hospital at about 1215 hours on 17th August 1998, Mrs LACK accompanied by her sister [Mrs MACKENZIE], found her mother to be screaming and in pain. The screaming ceased 'within minutes' when Mrs LACK and a registered general nurse repositioned Mrs Richards.

15.11. Subsequently, the X-ray at the Gosport War Memorial Hospital showed no fresh dislocation of the artificial hip.

15.12. Following this further X-ray, Mrs LACK told Dr BARTON that Haslar Hospital would be prepared to readmit her mother. Dr BARTON is reported to have '... felt that was inappropriate.' Mrs LACK '... considered this was essential so that the 'cause' of my mother's pain could be treated and not simply the pain itself.'

15.12.1. Dr BARTON is stated to have said to Mrs LACK that, '..."It was not appropriate for a 91 year old, who had been through two operations, to go back to Haslar Hospital where she would not survive further surgery." '

15.13. Mrs LACK states that, on 18th August 1998, the Ward Manager [Mr Philip BEED] explained to her and her sister that a syringe driver was going to be used. This was to ensure Mrs RICHARDS 'was pain free at all times' so that she would not suffer when washed, moved, or changed in the event she should become incontinent. Mrs LACK has also described in her contemporaneous notes (as well as in her Witness Statement, see below) that 'A little later Dr BARTON appeared and confirmed that a haematoma

was present and that this [the use of a syringe driver] was the kindest way to treat my mother. She [Dr BARTON] also stated "And the next thing will be a chest infection." '.

15.13.1. In her Witness Statement, Mrs LACK has recorded 'The outcome of the syringe driver was explained to my sister and I fully. Drawing on my experience as a nurse I [Mrs LACK] knew that the continuous use of morphine, as means of relieving her pain, could result in her death. She [Mrs RICHARDS] was, at the time, unconscious from the effects of previous doses of 'Oramorph'.... [paragraph] As result of seeing my mother in such great pain I was becoming quite distressed at this stage. My sister asked the Ward Manager, "Are we talking about euthanasia? It's illegal in this country you know." The Ward Manager replied, "Goodness, no, of course not." I was upset and said, "Just let her be pain free". [paragraph] The syringe driver was applied and my mother was catheterised to ease the nursing of her. She had not had anything by mouth since midday Monday 17th August 1998. [paragraph] A little later Dr BARTON [sic] appeared and confirmed that a haemetoma [sic] was present and that this was the kindest way to treat my mother. She also stated, "And the next thing will be a chest infection." .... [In her witness statement Mrs Mackenzie has stated that ' DR BARTON [sic] then said, "Well, of course, the next thing for you to expect is a chest infection".'][paragraph] I would like to clarify the issue of my 'agreement' to the syringe driver process. It was not a question, in my mind, of 'agreement'. [paragraph] I wanted my mother's pain to be relieved. I did not 'agree' to my mother being simply subjected to a course of pain relief treatment, at the Gosport War Memorial Hospital, which I knew would effectively prevent steps being taken to facilitate her recovery and would result in her death. [paragraph] I also wanted my mother to be transferred back to the Haslar Hospital where she had, on two occasions, undergone operations and recovered well. My mother was not, I knew, terminally ill and, with hindsight, perhaps I should have challenged Dr BARTON [sic] more strongly on this issue. [paragraph] In my severe distress I did not but I do believe that my failure to pursue the point more vigorously should not have prevented Dr BARTON [sic] from initiating an alternative course of action to that which was taken, namely a referral back to the Haslar Hospital where my mother's condition could have been treated and where an offer had already been made to do so. [paragraph] I accept that my mother was unwell and that her physical, reserves had been depleted. However, she had, during the preceding days and weeks, demonstrated great courage and strength. I believe that she should have been given a further chance of recovery especially in the light of the fact that her condition had, it would seem likely, been aggravated by poor quality service and avoidable delay experienced whilst in the hands of those whose responsibly [responsibility] it was to care for her. [paragraph] My mother's bodily strength allowed her to survive a further 4 days using her reserves. She suffered kidney failure on 19th August and no further urine was passed. The same catheter remained in place until

her death. [paragraph] Because the syringe driver was deemed to be essential following the night of several doses of pain relief my mother's condition gradually deteriorated during the next few days, as I knew it inevitably would, and she died on Friday the 21st August 1998.'

15.14. It is noted that Mrs LACK had made contemporaneous hand-written notes comprising five numbered pages. In her Witness Statement she records these '... are in the form of a basic chronology and I incorporated within them a series of questions which focused on particular areas of concern in respect of which I sought an explanation or clarification from the hospital authorities. Following presentation of my notes we were visited on the ward by Mrs Sue HUTCHINGS [sic] on 20.8.98.'

15.14.1. Mrs LACK also made a further one page of contemporaneous hand-written notes. In these she states she was so appalled about her mother's condition, discomfort and severe pain that she visited Haslar Hospital at about lunchtime on 17th August 1998 to ask questions about her mother's condition before she [Mrs RICHARDS] had left the Haslar Hospital ward for her second transfer to Gosport War Memorial Hospital. She learned that, prior to her discharge from Haslar Hospital on 17th August 1998, her mother had been eating, drinking, using a commode and able to stand if aided. Mrs LACK also states in this contemporaneous record that 'On leaving the ward [at Haslar Hospital at about lunchtime on 17th August 1998] I bumped into the Dr [doctor] who had been in casualty theatre for my mothers [sic] second [sic] operation. He was with consultant when all the procedures were explained to me on Friday 14th [August 1998] He said "How's your mother". I explained the current position to him in detail. I told him that she was in severe pain since the transfer which had been undertaken a short time earlier. He said "We've had no referral. Get them to refer her back. We'll see her."

15.15. It is noted that a Discharge Letter from the Royal Hospital Haslar describes Mrs RICHARDS' condition on discharge on 17th August 1998 as "She can, however, mobilise fully weight bearing."

15.16. It is also noted that Mrs LACK has stated that she and her sister were constantly at the Gosport War Memorial Hospital, day and night, from 17th August 1998 until the time their mother died.

15.16.1. Mrs MACKENZIE has stated that 'I stayed with my mother until very late that Tuesday night [18th August 1998]. it was past midnight, in fact, when my son arrived from London. As from the Wednesday night my sister also sat with me all night long and we both remained, continuously, until twenty past nine on the following Friday evening [21st August 1998] when my mother died. During that time Dr Barton [sic] did not visit my mother. I am quite certain about this because our mother was not left alone, in her room, at

any time apart from when she was washed by the nursing staff. Either my sister or I, [sic] was with her throughout.'

15.16.2. Mrs MACKENZIE has also stated that although she did not sign the contemporaneous notes made by Mrs LACK she '... was a party, at times, to the preparation process and where, on occasions, my sister has referred to 'I' in fact it could read 'we' as we were together when certain events occurred.'

15.16.3. Mrs MACKENZIE continues 'It seems to me that she [Mrs RICHARDS] must have had considerable reserves of strength to enable her to survive from Monday until Friday, five days, when all she had was a diet of Diamorphine and no hydration whatsoever, apart from porridge, scrambled eggs and a drink, at the Royal Hospital Haslar, before transfer to the Gosport War Memorial Hospital.'

Appendix C

Glossary

Acetabulum is the name given to the two deep socket into which the head of the thigh bone (femur) fits at the hip joint.

ADL [activities of daily living] are those physical activities of daily life necessary for normal human functioning and include getting up, washing, dressing, preparing a simple meal, etc.

Analgesia is the relief of pain. This can be achieved by physical means including warmth and comfortable positioning as well as by the use of drugs. The aim is to keep patients pain free with minimal side effects from medication.

Bronchopneumonia is inflammation of the lung usually caused by bacterial infection. Appropriate antibiotic therapy, based on the clinical situation and on microbiological studies, will result in complete recovery in the majority of patients. It can contribute to the cause of death in moribund patients.

Co-codamol is a drug mixture consisting of paracetamol and codeine phosphate, which is used for the relief of mild to moderate pain.

Cyclizine is a drug used to prevent nausea and vomiting, vertigo, and motion sickness.

Dementia is the name given to a condition associated with the acquired loss of intellect, memory, and social functioning.

Diamorphine, also known as heroin, is a powerful opioid analgesic.

Haematoma is an accumulation of blood within the tissues, which clots to form a solid swelling.

Haloperidol, a drug used in the treatment of psychoses including schizophrenia and mania and also for the short-term management of agitation, excitement, and violent or dangerously impulsive behaviour. Dosage for all indications should be individually determined and it is best initiated and titrated under close clinical supervision. For patients who are elderly the normal starting dose should be halved, followed by a gradual titration to achieve optimal response. It is not licensed for subcutaneous administration (see **licensed** below).

Hemiarthroplasty is the surgical remodelling of a part of the hip joint whereby the bone end of the femur is replaced by a metal or plastic device to create a functioning joint.

Hyoscine is a drug used to reduce secretions and it also provides a degree of amnesia and sedation, and has an anti-vomiting effect. Its side effects include drowsiness.

Lactulose is a preparation taken by mouth to relieve constipation.

A **microgram** is one millionth of a gram and is not to be confused with a milligram dosage of a drug, which is one thousand times larger.

Midazolam is a sedative drug about which there have been reports of respiratory depression. It has to be use with caution in elderly people. It is used for intravenous sedative cover for minor surgical procedures. It is also used for sedation by intravenous injection in critically ill patients in intensive care. It can be given intramuscularly. In the management of overdosage special attention should be paid to the respiratory and cardiovascular functions in intensive care. It is not licensed for subcutaneous administration (see **licensed** above).

Morphine is an opioid analgesic used to relieve severe pain.

Oramorph is a drug used in the treatment of chronic pain. It contains morphine and is in the form of a liquid. 10mls of Oramorph at a strength of 10mgs of morphine sulphate in 5mls of liquid is an appropriate first dose to give to a person in severe pain, which had not responded to other less potent, pain relieving drugs.

Respiratory depression is the impairment of breathing by drugs or mechanical means which leads to asphyxia and, if uncorrected, to death.

Subcutaneous means beneath the skin.

A **syringe driver** is a power driven device for pushing the plunger of a syringe forward at an accurately controlled rate. It is an aid to administering medicinal preparations in liquid form over much longer periods than could be achieved by injecting by hand. In this case the syringe driver used was a Sims Graseby MS 26 Daily rate syringe driver which operates over periods of 24-hours.

Tradazone is a drug used in the treatment of depressive illness, particularly when sedation is required.

Unlicensed medicines. In order to ensure that medicines are safe, effective and of suitable quality, they must have a product licence (now called a market authorisation) before being marketed in the United Kingdom. Unlicensed drugs are not licensed for use for any indication or age group. Licensing arrangements constrain pharmaceutical companies but not prescribers. The Medicines Act 1968 and European legislation make provision for doctors to use unlicensed medicines. Individual prescribers of unlicensed medicines, however, are always responsible for ensuring that there is adequate information to support the quality, efficacy, safety and intended use of a drug before using it.

A **Zimmer frame** is a lightweight, but sturdy, frame the patient can use for support to assist safe walking.

APPENDIX D

Texts used for reference have included:

1. Adam J. ABC of palliative care: The last 48 hours. *British Medical Journal* 1997; 315: 1600-1603.

    1.1. This paper is from the widely read, British Medical Journal which is published weekly and received by about 30,000 general practitioners and 45,000 hospital doctors in England and Wales. It records that treatment with opioids (viz. morphine and diamorphine) should be individually tailored, the effect reviewed, and the dose titrated accordingly.

2. *ABPI Compendium of data sheets and summaries of product characteristics 1998-99: with the code of practice for the Pharmaceutical Industry*. Datapharm Publications Limited, 12 Whitehall, London SW1A 2DY.

3. Breggin P R. *Toxic psychiatry. Drugs and electroconvulsive therapy: the truth and the better alternatives*. 1993. HarperCollins Publishers. London. pp. 578.

4. British Medical Association and the Royal Pharmaceutical Society of Great Britain. *British National Formulary*. Number 32 (September 1996). The Pharmaceutical Press. Oxford.

5. *Cecil Textbook of Medicine*. eds. J.C. Bennett & F. Plum. W.B. Saunders Co. 20th Edition. 1996.

6. Letter from Clive Ward-Able (Medical and Healthcare Director) and Lee Neubauer BSc (Hons) (New Product Specialist), Roche Pharmaceuticals.

    6.1. A copy of this letter has already been supplied to the Police and reports that the product licence does not cover the administration of Hypnovel® (midazolam) by subcutaneous injection.

7. Roche Pharmaceuticals. Hypnovel® [midazolam]. Summary of product characteristics.

8. Letter from Dr R J Donnelly, Medical Director of Janssen-Cilag Ltd.

    8.1. A copy of this letter has already been supplied to the Police and reports that Haldol™ decanoate (haloperidol) is not licensed for subcutaneous use.

9. Letter from Miss Jo Medlock, Manager of Medical Information and Pharmacovigilance, Norton Pharmaceuticals.

    9.1. A copy of this letter has already been supplied to the Police and reports that Serenace™ (haloperidol) ampoules are not licensed for subcutaneous administration.

10. MeReC. Pain control in palliative care. *MeReC Bulletin National Prescribing Centre*. 1996; 7 (7); 25-28.

    10.1. MeReC is the abbreviation for the 'Medicines Resource Centre'. This bulletin is sent free to all general practitioners in England and Wales and also to NHS Hospital and Community Pharmacists. The list of those who receive this bulletin is updated every few weeks.

11. Sims Graseby Limited. *MS 16A Syringe Driver. MS 26 Syringe Driver: Instruction manual*. Sims Graseby Limited. 1998.

Appendix E

The writer's qualifications and experience including the management of dying patients

I, Brian Livesley, qualified MB, ChB (Leeds) in 1960.
My principal additional qualifications are MD (London) 1979, FRCP (London) 1989.

From 1961-69, I held a series of clinical training and teaching posts through all hospital medical grades to senior medical registrar level at University and District Hospitals in Leeds, Manchester and Liverpool in which I gained a wide range of general medical expertise.

At the beginning of my medical career during 1961, I was also trained in the management of diabetic patients in Leeds by Professor (later Sir) Ronald Tunbridge. For five years (1963-67), I held a regular weekly diabetic out-patient clinic in Manchester (two diabetic clinics each week during 1963-65) being also responsible for the acute and follow-up management of newly presenting diabetic patients as well as having a full range of general medical experience.

For four years (1969-72), I was Harvey Research Fellow in cardiology at King's College Hospital, London, where I developed original research in electrocardiographic, cardiac pacing, and metabolic techniques for the study of ischaemic heart disease. This also involved extensive follow-up studies over a period of more than six years. The several and separate aspects of this work were published in internationally reputable professional journals and now form part of the corpus of present day knowledge in cardiology. My continuing interest in this area led me to specialise in geriatric medicine with some emphasis on cardiology in elderly people.

I have been a consultant physician since 1973 and am entered in the General Medical Council's Principal List as a specialist in both General Medicine and Geriatric Medicine.

In 1987, I was appointed against open competition to a Foundation Chair as the University of London's Professor in the Care of the Elderly based at Charing Cross and Westminster Medical School (now the Imperial College School of Medicine) and as Honorary Consultant Physician.

I am in active clinical practice at the Chelsea & Westminster Hospital, London, where I head up a busy clinical department consisting of three consultant-led medical teams. These are all routinely involved in the emergency medical admissions and follow-up management of adults of all ages including those with diabetes mellitus, cardiac, respiratory, and skeletal diseases. During the last two years I have developed one other team that is providing a palliative care service for non-cancer patients.

Since 1969 I have taught not only undergraduate and postgraduate medical students, but also by invitation have lectured (throughout the United Kingdom, Europe, and elsewhere) to a wide range of other groups—professional and lay. I have also initiated and led courses teaching and appraising senior medical teachers. For fifteen years (1980-94), I served as a clinical examiner for the Final MB degree at the University of London—latterly (1990-94) as a senior clinical examiner. For six years (1987-93), I also examined in Medicine for the Worshipful Society of Apothecaries of London. For seven years (1986-93), I was Royal College of Physicians of London Examiner for the Diploma of Geriatric Medicine; and, for two years (1994-96) was an appointed Member of the United Examining Board for England and Scotland. In addition, I have examined externally for the degrees of BPharm and PhD. During 1998, 1999, & 2000 I have been an invited external clinical examiner for the Final MB degree at the Royal Free and

University College London Medical School where by recent invitation I will examine the candidates being considered for a Distinction in 2001.

In 1991, by invitation, I addressed a House of Lords group on issues relating to the clinical management of elderly people.

In 1992, I was one of a team at the Royal College of Physicians who contributed to the College's publication entitled, 'High quality long-term care for elderly people.'

From 1983-1995 I was a Justice of the Peace for the SE London Commission of the Peace having to stand down following a invitation in 1995 to head up a comprehensive review of the care provided in a 150-bedded nursing home. In 1996 all 16 recommendations in the resulting 40,000-word report were accepted and acted upon by the commissioning Health Agency (1). Also in 1996, I gave invited evidence on this topic to a Health Committee in the House of Commons (2).

In 1999 and again in 2000, the King's Fund in London identified the work in my clinical department as a national model for the care of elderly people.

In July 2000, I was the only clinician to give a presentation by invitation at a meeting on "Emerging Intermediate Care Strategy — 'Leading edge' Practice" held at the Royal College of Surgeons of England, London. This was well received and repeated by invitation in the North of England in November 2000.

During 1999 and 2000 I was working with the British Medical Association's Ethics department on the topics of 'dying as a diagnosis' and 'the appropriate care of the dying'. In addition, I have recently chaired a medico-legal group within my NHS Hospital Trust and produced a report on 'Guidelines for the artificial nutrition of patients affected by strokes'. My clinical, teaching, and research work on the management of dying patients extends over the last twenty five years and I was a leader of the concept that 'dying should be a recognised diagnosis' to allow for the appropriate palliative care of patients dying from non-cancer conditions. More recently I have established an original palliative care service for non-cancer patients in my own department at the Chelsea & Westminster hospital where we are pursuing research in this topic.

My over 120 publications include several monographs, many peer-reviewed research investigations into clinical, scientific, social, historical, and educational problems of medicine in our ageing society, editorials and leading articles by invitation of professional journals, and, in addition by invitation, more than 100 standard and extended book reviews. My peer-reviewed publications also include those on the clinical management of dying patients.

References as numbered above:

1. Livesley B, Ellington S. Report on the independent comprehensive review of the care of elderly people at St. Christopher's Nursing Home, Hatfield. East and North Hertfordshire Health Authority, 1996. (by invitation)

2. Livesley B. Memorandum of recommendations and evidence submitted to the Health Committee on long-term care provision and funding. Volume II; pp. 114-22. London: HMSO, 1996. (by invitation)

signed ...Code A... date 10 July 2001

BRIAN LIVESLEY

Frimley Park Hospital NHS
NHS Trust

Portsmouth Road
Frimley
Camberley
Surrey
GU16 7UJ

Tel: 01276 604604
Fax: 01276 604148

Elderly Care Unit
Telephone: Code A (direct line)
Fax: 01276 604882 (direct into Secretaries' office)

KIM/gnt/gosport

18 October 2001

CONFIDENTIAL

Detective Superintendent J James
Hampshire Constabulary
Major Incident Complex
Kingston Crescent
North End
PORTSMOUTH
PO2 8BU

Dear DS James

CONFIDENTIAL MEDICAL REPORT REGARDING MEDICAL MANAGEMENT OF PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL

Thank you for asking me to give a report on the management of four patients who died at Gosport War Memorial Hospital. I have based my personal opinion on my qualification as a specialist in geriatric medicine, my 13 years experience as a Consultant Geriatrician with several years experience working at the local hospice.

USE OF OPIOID ANALGESICS

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. The guidance in the BNF suggests that non-opioid analgesics such as Aspirin or Paracetamol should be used as first line treatment and occasionally non-steroidal anti-inflammatory drugs may help in the control of bone secondaries. If these drugs are inadequate to control the pain of moderate severity then a weak opioid such as Codeine or Dextropropoxyphene should be used either alone or in combination with the simple pain killers in adequate dosage. If these weak opioid preparations are not controlling the pain Morphine is the most useful opioid analgesic and is normally given by mouth as an oral solution every 4 hours, starting with a dose between 5 mg and 20 mg, the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and use of other drugs should also be considered. If the pain is not well controlled the dose should be increased in a step-wise fashion to control the pain.

CASE NOTE REVIEWS

1 ARTHUR CUNNINGHAM

Mr Cunningham was known to suffer with depression, Parkinson's disease and cognitive impairment with poor short term memory. He suffered with long standing low back pain following a spinal injury sustained in the Second World War which required a spinal fusion. He suffered with hypertension and non insulin diabetes mellitus, had a previous right renal stone removed, and bladder stones, and had a previous trans-urethral prostatectomy. Myelodysplasia had been diagnosed (a bone marrow problem affecting the production of the blood constituents). Mr Cunningham had a one month admission under the care of Dr Banks for depression in July and August 1998.

Mr Cunningham was admitted by Dr Lord, Consultant Geriatrician from the Dolphin Day Hospital to Dryad Ward at Gosport War Memorial Hospital on 21 09 1998 because of a large necrotic sacral ulcer with a necrotic area over the left outer aspect of the ankle (these are signs of pressure sores). Dr Lord's intention was to give more aggressive treatment to the sacral ulcer. He was seen by Dr Barton. A dose of 2.5 mg to 10 mg of Oromorph 4 hourly was prescribed and he was given 5 mg prior to his sacral wound dressing at 1450 and a further dose of 10 mg at 2015. Diamorphine via a syringe driver was prescribed at a dose of 20 mg to 200 mg in 24 hours and this was commenced at a dose of 20 mg for 24 hours with Midazolam at 2300 on 21 09 1998. Dr Barton reviewed the patient on 23 September when he was said to be "chesty", Hyoscine was added to the syringe driver and the dose of Midazolam was increased. The patient was noted to be in some discomfort when moved on that day and the next day he was said to be "in pain" and the Diamorphine dose was increased to 40 mg for 24 hours, then 60 mg the following day and 80 mg on the 26 September, there being no further comments as to the patient's condition. The dose of Midazolam and Hyoscine was also increased. The patient died at 2315 on 26 09 1998.

Comments

All the prescriptions for opiod analgesia are written in the same hand, and I assume they are Dr Barton's 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 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. The patient was reviewed by Dr Barton 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.

2 ALICE WILKIE

Miss Wilkie was known to suffer with severe dementia, depression and rectal bleeding attributed to piles. She had been admitted to Philip Ward with a urinary tract infection and immobility under the care of Dr Lord and a decision was made to transfer her to Daedalus ward at Gosport War Memorial Hospital for a few weeks observation prior to a decision on placement. She was transferred on the 6 August and was seen by Dr Peters. The nurses recorded that the patient was complaining of pain but it was difficult to establish the nature or site of this pain. Diamorphine was prescribed on 20 08 1998 in a dose of 20 mg to 200 mg per 24 hours and the signature is identical to that on Mr Cunningham's case which I assume is Dr Barton's. A dose of 30 mg was given on 20 08 1998 with Midazolam and an entry in the notes, again apparently by Dr Barton, comments on a "marked deterioration over last few days". The patient was given another 30 mg of Diamorphine on 21 08 1998 and died that day at 1830. The patient was said to be comfortable and pain free by the nursing staff on the final day.

Comments

There was no clear indication for an opiod 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.

3 ROBERT WILSON

Mr Wilson was known to suffer with alcohol abuse with gastritis, hypothyroidism and heart failure. He was originally admitted via Accident & Emergency on the 22 September with a fractured left humerus and transferred to Dickens Ward under the care of Dr Lord. His fracture was managed conservatively. In view of the severe pain he received several doses of Morphine and was prescribed regular Paracetamol.

He was reviewed by Dr Luznat, Consultant Psychogeriatrician, who felt he had an early dementia and depression and recommended an anti-depressant. He was also noted to have poor nutrition.

Dr Lord made a decision to transfer Mr Wilson for a "short spell to a long term NHS bed" with the aim of controlling his pain and presumably to try to rehabilitate him. He was accordingly moved to Dryad ward at Gosport War Memorial Hospital on the 14 October. The transfer letter from Dickens

ward shows that he was still " in a lot of pain in arm".

The prescription appears to have been written by Dr Barton once again. Paracetamol was prescribed but never given by the nursing staff. Oramorph was prescribed 10 mg 4 hourly and 20 mg nocte commencing on 15 10 1998 and the night time dose was given with "good effect" as judged by the nursing staff. The nursing report goes on to say that Mr Wilson had become "chesty" and had "difficulty in swallowing medications". Oramorph was also prescribed 5 mg to 10 mg as required 4 hourly and four doses were given, suggesting Mr Wilson was in persisting pain. on 16 10 1998 the patient was seen by Dr Knapman. The patient was said to be unwell, breathless, unresponsive with gross swelling of the arms and legs. No ECG or oxygen saturation was recorded but the patient's dose of Frusemide (a diuretic) was increased, so I assume the patient was thought to have worsening heart failure. The nurses report a "very bubbly chest". A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16 10 1998 again, in Dr Barton's handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of Diamorphine was given on 16 10 1998 and the nurses commented later that the "patient appears comfortable", the dose was increased to 40 mg the next day when copious secretions were suctioned from Mr Wilson's chest. On 18 10 1998 the patient was seen by Dr Peters and the dose of Diamorphine was increased to 60 mg in 24 hours and Midazolam and Hyoscine were added. The patient died on 18 10 1998 at 2340 hours.

Comments

Mr Wilson was clearly in pain from his fractured arm at the time of transfer to Dryad ward. Simple analgesia was prescribed but never given (there was an entry earlier in the episode of care that Mr Wilson had refused Paracetamol). No other analgesia was tried prior to starting morphine. Mr Wilson 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 again the Diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson'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 Dr Lord on 29 09 1998.

4 EVA PAGE

Mrs Page was 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. She was admitted on 06 02 1998 to Victory Ward with nausea, anorexia and dehydration and had recently been treated for depression. She was transferred to Charles Ward on 19 02 1998 and had been noted to have a 5 cm mass on chest

x-ray compatible with a lung cancer. She was transferred to Dryad ward, Gosport Memorial Hospital on 27 02 1998 for palliative care. On arrival she was noted to be calling out frequently, and anxious. She was prescribed Thioridazine (a tranquilliser) but this did not relieve her distress and she was prescribed Oramorph 5 mg to 10 mg as required 4 hourly, I believe, by Dr Barton. The nurses report "no relief". She was seen by another doctor who was not named in the nursing record who prescribed regular Thioridazine and Heminevrin at night. On 01 03 1998 it is recorded that Mrs Page "spat out medication", on 02 03 1998 there was an entry, I believe by Dr Barton, stating "no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain". He prescribed a Fentanyl patch 25 mg (another opioid which can be given as a skin patch) and the prescription was countersigned by Dr Lord, I believe. The nursing records state she was "very distressed", she was reviewed by Dr Barton and Diamorphine 5 mg intramuscularly was given. She was then seen by Dr Lord and a further dose of intramuscular 5 mg Diamorphine was given. On 03 03 1998 a syringe driver was started, prescribed, I believe, by Dr Barton, at a dose of 20 mg to 200 mg in 24 hours. The initial dose given was 20 mg of Diamorphine with Midazolam which was started at 1050. The nurses record "rapid deterioration .... right side flaccid". The patient died at 2130 that evening.

Comments

Mrs Page 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 she was given a topical 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 was clear that her physical condition deteriorated rapidly and I suspect 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 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 chart is, in my view, unacceptable. In my view the dose of Diamorphine should be prescribed on a regular basis and reviewed regularly by 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 dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Dr Lord and Dr Barton 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 prescriber did not comply with standard practise. 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 require further consideration by the Hospital Trust.

I trust this report contains all the essential information you require. Please let me know if you wish me to give any further comment.

Yours sincerely

Code A

DR K I MUNDY FRCP
CONSULTANT PHYSICIAN AND GERIATRICIAN

MEDICO-LEGAL REPORT

Re: **Gladys Mabel RICHARDS**
Arthur "Brian" CUNNINGHAM
Alice WILKE
Robert WILSON
Eva PAGE

Prepared by:

Professor G A Ford, MA, FRCP
Consultant Physician, Freeman Hospital
Newcastle upon Tyne
Professor of Pharmacology of Old Age, University of Newcastle upon Tyne

For: **Hampshire Constabulary**

Date: **12th December 2001**

Contents

8 Introduction and remit of the report
9 Report on Gladys Mabel Richards
10 Report on Arthur "Brian" Cunningham
11 Report on Alice Wilkie
12 Report on Robert Wilson
13 Report on Eva Page
14 Opinion on clinical management at Gosport War Memorial Hospital
15 Appendix 1 – Pharmacology of opiate and sedative drugs
16 Appendix 2 – British National Formulary guidelines on prescribing in palliative care and prescribing in the elderly

Introduction and Remit of the Report

8.1 I am Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology at the University of Newcastle upon Tyne, and a Consultant Physician in Clinical Pharmacology at Freeman Hospital. I am a Doctor of Medicine and care for patients with acute medical problems, acute poisoning and stroke. I have trained and am accredited on the Specialist Register in Geriatric Medicine, Clinical Pharmacology and Therapeutics and General Internal Medicine. I provide medical advice and support to the Regional Drugs and Therapeutics Centre Regional National Poisons Information Service. I was previously clinical head of the Freeman Hospital Care of the Elderly Service and have headed the Freeman Hospital Stroke Service since 1993. I undertake research into the effects of drugs in older people. I am co-editor of the book 'Drugs and the Older Population' and in 2000 was awarded the William B Abrams award for outstanding contributions to Geriatric Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a Fellow of the Royal College of Physicians and have practised as a Consultant Physician for nine years.

8.2 I have been asked by Detective Superintendent John James of Hampshire Constabulary to examine the clinical notes of five patients (Gladys Mabel Richards, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson, Eva Page) treated at the Gosport War Memorial Hospital and to apply my professional judgement to the following:

- The gamut of patient management and clinical practices exercised at the hospital
- Articulation of the leadership, roles, responsibilities and communication in respect of the clinicians involved
- The accuracy of diagnosis and prognosis including risk assessments
- An evaluation of drugs prescribed and the administration regimes
- The quality and sufficiency of the medical records
- The appropriateness and justification of the decisions that were made
- Comment on the recorded causes of death
- Articulate the duty of care issues and highlight any failures

1.3 I have prepared individual reports on each case and an additional report commenting on general aspects of care at Gosport War Hospital from a consideration of all five cases.

1.4 I have been provided with the following documents by Hampshire Constabulary, which I have reviewed in preparing this report:

- Comment on the recorded causes of death
- Letter DS J James dated 15th August 2001
- Terms of Reference document
- Hospital Medical Records of Gladys Richards, Brian Cunningham, Alice Wilkie, Robert Wilson and Eva Page
- Witness statements by Leslie France Lack, and Gillian MacKenzie
- Report of Professor Brian Livesley
- Transcripts of police interviews with Gosport War Memorial staff Dr Barton, Mr Beed, Ms Couchman, Ms Joice

- Transcript of police interviews with Royal Hospital Haslar staff Dr Reid and Flt. Lt. Edmondson
- Transcript of interviews with patient transfer staff Mr Warren and Mr Tanner
- Transcript of police interviews with or statements from following medical and nursing staff: Dr Lord, LM Baldacchino, M Berry, JM Brewer, J Cook, E Dalton, W Edgar, A Fletcher, J Florio and A Funnell.

Gladys Mabel RICHARDS

Course of Events

2.1 Gladys Richards was 91 years old when admitted as an emergency via the Accident & Emergency Department to Haslar Hospital on 29Th July 1998. She had fallen onto her right hip and developed pain. At this time she lived in a nursing home and was diagnosed as having dementia. She had experienced a number of falls in the previous 6 months and the admission notes comments "*quality of life has ↓↓ markedly last 6/12*". She was found to have a fracture of the right neck of femur. An entry in the medical notes by Surgeon Commander Malcom Pott, Consultant orthopaedic surgeon dated 30 July 1998 states '*After discussion with the patient's daughters in the event of this patient having a cardiac arrest she is NOT for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished.*' Surgery (right hemiarthroplasty) was performed on 30 July 1998.

2.2 On 3rd August she was referred for a geriatric opinion and seen by Dr Reid, Consultant Physician in Geriatrics on 3rd August 1998. In his letter dated 5th August 1998 he notes she had been on treatment with haloperidol and trazadone and that her daughters thought she had been 'knocked off' by this medication for months, and had not spoken to then for 6-7 months. Her mobility had deteriorated. Her daughters commented to Dr Reid that she had spoken to them and had been brighter mentally since the trazadone had been omitted following admission. Dr Reid found Mrs Richards to be confused but pleasant and cooperative, unable to actively lift her right leg from the bed but appeared to have little discomfort on passive movement of the right hip. He commented '*I understand she has been sitting out in a chair and I think that despite her dementia, she should be afforded the opportunity to try to re-mobilise her.* He arranged for her transfer to Gosport War Memorial Hospital.

2.3 Following Dr Reid's entry in the notes on 3rd August two further entries are made in the medical notes by the on call house officer (Dr Coales?) on 8th August 1998. Dr Coales was asked to see Mrs Richards who was agitated on the ward. She had been given 2mg haloperidol and was asleep when first seen at 0045h. At 02130 hr a further entry records Mrs Richards was '*noisy and disturbing other patients n ward. Unable to reason with patient. Prescribed 25mg thioridazine'.* A transfer letter for Sergeant Curran, staff nurse to the Sister in Charge dated 10th August 1998 describes Mrs Richards status immediately prior to transfer and notes '*Is now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Gladys needs total care with washing and dressing eating and drinking. Gladys is continent, when she becomes fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes.*

2.4 On 11th August 1998 Mrs Richards was transferred to Daedalus ward. Dr Barton writes *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 summary admitting nursing notes record "*now fully weight bearing and walking with the aid of two nurses and a Zimmer frame*". On 12th August the nursing notes record "*Haloperidol given at 2330 as woke from sleep. Very agitated, shaking and crying. Didn't settle for more than a few*

minutes at a time. Did not seem to be in pain".On 13th August nursing notes record "*found on floor at 1330h. Checked for injury none apparent at time. Hoisted into safer chair. 1930 pain Rt hip internally rotated, Dr Brigg contacted advised Xray am and analgesia during the night. Inappropriate to transfer for Xray this pm."*

2.5 On 14th August 1998 Dr Barton wrote '*sedation/pain relief has been a problem. Screaming not controlled by haloperidol 1g ? but very sensitive to Oramorph. Fell out of chair last night. R hip shorter and internally rotated, Daughter nurse and not happy. Plan Xray . Is this lady well enough for another surgical procedure?"* A further entry the same day states "*Dear Cdr Spalding, further to our telephone conversation thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her R hip. Hemiarthroplasty was done on 30-8-98. I am sending Xrays. She has had 2.5ml of 10mg/5ml oramoroph at midday. Many thanks*".

2.6 Following readmission to Haslar hospital Mrs Richards underwent manipulation of R hip under iv sedation (2 mg midazolam) at 1400h. At 2215h the same day she was not responding to verbal stimulation but observations of blood pressure, pulse, respiration and temperature were all in the normal range. A further entry on 17th August by Dr Hamlin (House Officer) states "*fit for discharge today (Gosport War Mem) To remain in straight knee splint for 4/52. For pillow between legs (abduction) at night.*" A transfer letter to the nurse in charge at Daedalus ward states "*Thank you for taking Mrs Richards back under your care... was decided to pass an indwelling catheter which still remains in situ. She has been given a canvas knee immobilising splint to discourage any further dislocation and this must stay in situ for 4 weeks. When in bed it is advisable to encourage abduction by using pillows or abduction wedge. She can however mobilise fully weight bearing*".

2.7 Nursing notes record on 17th August " 1148h *returned from R.N.Haslar patient very distressed appears to be in pain. No canvas under patient – transferred on sheet by crew."* Later that day at 1305h "*in pain and distress, agreed with daughter to give her mother Oramorph 2.5mg in 5ml*". A further hip Xray was performed which demonstrated no fracture. Dr Barton writes on 17th August 1998 *"readmission to Daedalus ward. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Can continue haloperidol, only for Oramorph if in severe pain. See daughter again"* and on 18th August "*still in great pain, nursing a problem, I suggest sc diamorphine/ haloperidol/midazolam. I will see daughters today. Please make comfortable*". Nursing notes record "*reviewed by Dr Barton for pain control via syringe driver*". At 2000h "*patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs*". On 19th August the nursing notes record "*Mrs Richards comfortable*" and in a separate entry "*apparently pain free*". There are no nursing entries I can find on 20th August. I can find no entries in the nursing notes describing fluid or food intake following admission on 17th August.

2.8 The next entry in the medical notes is on 21st August by Dr Barton "*much more peaceful. Needs hyoscine for rattly chest*". The nursing notes record "*patient's overall condition deteriorating. Medication keeping her comfortable*". A staff

nurse records Mrs Richards's death in the notes at 2120h later that day. The cause of death was recorded as *bronchopneumonia*.

2.9 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards's first admission to Haslar Hospital.

29 July 2000h Trazadone 100mg (then discontinued)
29 July to 11th August. Haloperidol 1mg twice daily
30 July 0230h Morphine iv 2.5mg
31 July 0150h morphine iv 2.5mg
1905h morphine iv 2.5 mg
1 Aug 1920h morphine iv 2.5mg
2 Aug 0720h morphine iv 2.5mg
Cocodamol two tablets as required taken on 16 occasions at varying times between 1-9th August

2.10 Medication charts record the following administration of opiate, analgesic and sedative drugs during Mrs Richards second admission to Haslar Hospital

14 Aug 1410h midazolam 2mg iv
15 Aug 0325h cocodamol two tablets orally
16 Aug 0410h haloperidol 2mg orally
0800h haloperidol 1mg orally
1800h haloperidol 1mg orally
2310h haloperidol 2mg orally
!7 Aug 0800h haloperidol 1mg orally

2.11 Medication charts record the following administration of opiate and sedative drugs on Daedalus ward:

11 Aug	1115h	5mg/5ml Oramorph
	1145h	10 mg Oramorph
	1800h	1 mg haloperidol
12 Aug	0615h	10 mg Oramorph
		haloperidol
13 Aug	2050h	10mg Oramorph
14 Aug	1150h	10mg Oramorph
17 Aug	1300h	5mg Oramorph
	?	5 mg Oramorph
	1645h	5mg Oramorph
	2030h	10mg Oramorph
18 Aug	0230h	10mg Oramorph
	?	10mg Oramorph
	1145h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hrby
19 Aug	1120h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
20 Aug	1045h	diamorphine 40mg/24hr, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr
21 Aug	1155h	diamorphine 40mg/24h, haloperidol 5mg/24hr midazolam 20mg/24hr, hyoscine 400microg/24hr

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

2.12 Primary responsibility for the medical care of Mrs Richards during her two admissions to Gosport Hospital lay with Dr Lord, as the consultant responsible for his care. My understanding is that day-to-day medical care was delegated to the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital (statement of Dr Lord in interview with DC Colvin and DC McNally). Primary responsibility for the medical care of Mrs Richards during her two admissions to Queen Alexandra Hospital lay with Surgeon Commander Scott, Consultant Orthopaedic Surgeon. Junior medical staff were responsible for day-to-day medical care of Mrs Richards whilst at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Richards and informing medical staff of any significant deterioration.

2.13 Dr Reid, Consultant Geriatrician was responsible for assessing Mrs Richards and making recommendations concerning her future care following her orthopaedic surgery, and arranged transfer to Gosport Hospital for rehabilitation.

Accuracy of diagnosis and prognosis including risk assessments

2.14 The initial assessment by the orthopaedic team was in my opinion competent and the admitting medical team obtained a good history of her decline in the previous six months. Surgeon Commander Pott discussed management options with the family and a decision was made to proceed with surgery but for Mrs Richards to not undergo cardiopulmonary resuscitation if she sustained a cardiac arrest, with a clear decision to keep Mrs Richards pain free, hydrated and nourished. There are good reasons to offer surgery for a fractured neck of femur to very frail patients with dementia even when a high risk of peri-operative death or complications is present. This is because without surgery patients continue to be in pain, remain immobile and nearly invariably develop serious complications such as pneumonia and pressure sores, which are usually fatal. From the information I have seen I would, as a consultant physician/geriatrician recommended the initial management undertaken. I consider it good management that the trazadone as discontinued when the history from the daughters suggested this might have been responsible for decline in the recent past.

2.15 After Mrs Richards was stable a few days following surgery it was appropriate to refer her for a geriatric opinion, and Dr Reid rapidly provided this. Dr Reid's assessment was in my opinion thorough and competent. He identified the potential for her to benefit from rehabilitation. I would consider his decision to refer her for rehabilitation despite her dementia to be appropriate. An elderly care rehabilitation, rather than an acute orthopaedic ward is in general a preferable environment to undertake such rehabilitation. It is implicit in his decision to transfer her to Gosport War Memorial Hospital that she would receive rehabilitation there and not care on a continuing care ward without input from a rehabilitation team. Dr Lord in an interview with DC McNally and DC Colvin describes Daedalus ward as "*Back in '98 .. Daedalus was a continuing care ward with 24 beds of which 8 beds were for slow stream stroke*

rehabilitation". Although Mrs Richards had a fractured neck of femur and not stroke as her primary problem requiring rehabilitation I would assume, in the light of Dr Reid's letter that she was transferred to one of the 8 slow stream rehabilitation beds on Daedalus ward.

2.16 The transfer letter from Sergeant Curran provides a clear description of Mrs Richards's status at the time of transfer. The observation that she was walking with the aid of two nurses and a zimmer frame, and the usual cause of agitation was when she needed to use the toilet are relevant to subsequent events following transfer to Gosport Hospital. The use of a Barthel Index score as a measure of disability is good practice and demonstrates that Mrs Richards was severely dependent at the time of her transfer to Gosport Hospital.

2.17 The initial entry by Dr Barton following Mrs Richards' transfer to Daedalus ward does not mention that she has been transferred for rehabilitation, and focuses on keeping her 'comfortable' despite recording that she is "*not obviously in pain*". The statement '*I am happy for nursing staff to confirm death*" also suggests that Dr Barton's assessment was that Mrs Richards might die in the near future. Dr Barton in her statement to DS Sackman and DC Colvin, confirms this when she states "*I appreciated that there was a possibility that she might die sooner rather than later*". Dr Barton refers to her admission as a "*holding manoeuvre*" and her statement suggests a much more negative view of the potential for rehabilitation. She does not describe any rehabilitation team or focus on the ward and suggests her transfer was necessary because she was not appropriate for an acute bed, rather than her being appropriate for rehabilitation- "*.her condition was not appropriate for an acute bed. ....seen whether she would recover and mobilise after surgery. If as was more likely she would deteriorate due to her age, her dementia, her frail condition and the shock of the fall followed by the major surgery, then she was to be nursed in a clam environment away from the stresses of an acute ward*". In my opinion this initial note entry and the statement by Dr Baron indicate a much less proactive view of rehabilitation, less appreciation than Dr Reid of the potential for Mrs Richards to recover to her previous level of functioning, and probably a failure to appreciate the potential benefits of appropriate multidisciplinary rehabilitation to Mrs Richards. This leads me to believe that Dr Barton's approach to Mrs Richards was in the context of considering her as a continuing care patient who was likely to die on the ward. It was not wrong or incorrect of Dr Barton to believe Mrs Richards might die on the ward, but I would consider her apparent failure to recognise Mrs Barton's rehabilitation needs may have led to subsequent sub-optimal care.

2.18 There are a number of explanations and contributory factors that may have led to Dr Barton possibly not recognising Mrs Richard's rehabilitation needs in addition to her nursing and analgesic needs. First she may have not clearly understood Dr Reid's assessment that she needed rehabilitation. In her statement Dr Barton states " *Dr Reid was of the view that, despite her dementia, she should be given the opportunity to try to remobilise*" which suggests Dr Barton may not have considered the necessity for Mrs Richards to receive Physiotherapy as a necessary part of her opportunity to remobilise. Second the ward had both continuing care and rehabilitation beds and these patients may require very different care. It is not uncommon for "slow stream" rehabilitation beds to be in the same ward as continuing care beds, but it does

require much broader range of care to meet the medical and social needs of these patients. I would anticipate that some patients would move from the slow stream rehabilitation to continuing care category. Dr Lord describes the existence of fortnightly multidisciplinary ward case conference suggesting there was a structured team approach that would have made Dr Barton and nursing staff aware of rehabilitation needs of patients. In Mrs Richards's case no such case conference took place because she became too unwell in a short period. Third Dr Barton may not have received sufficient training or gained adequate experience of rehabilitation or geriatrics despite working under the supervision of Dr Lord. Dr Lord states that Dr Barton was "*an experienced GP*" who had rights of admission to a GP ward and that Dr Lord had admitted patients "*under her care say for palliative care*". Experience in palliative care may possibly have influenced her understanding and expectations of rehabilitating older patients.

2.19 The assessment of Mrs Richard's agitation the following day on 12th August was in my opinion sub-optimal. The nursing records state that she did not appear to be in pain. There is no entry from Dr Barton this day but in her statement she states which I have some difficulty in interpreting: "*When I assessed Mrs Richards on her arrival she was clearly confused and unable to give any history. She was pleasant and co-operative on arrival and did not appear to be in pain. Later her pain relief and sedation became a problem. She was screaming. This can be a symptom of dementia but could also be caused by pain. In my opinion it was caused by pain as it was not controlled by Haloperidol alone. Screaming caused by dementia is frequently controlled by this sedative. Given my assessment that she was in pain I wrote a prescription for a number of drugs on 11th August, including Oramorph and Diamorphine. This allowed nursing staff to respond to their clinical assessment of her needs rather than wait until my next visit the following day. This is an integral part of team management. It was not in fact necessary to give diamorphine over the first few days following her admission but a limited number of small doses of Oramorph were given totalling 20mg over the first 24 hours and 10mg daily thereafter. This would be an appropriate level of pain relief after such a major orthopaedic procedure*".

2.20 I am unable establish from the notes and Dr Barton's statement whether she saw Mrs Richards in pain after she wrote in the notes and then wrote up the opiate drugs later on the 11th August, or if she wrote up these drugs after seeing her when she was not in pain, because she considered she might develop pain and agitation. In either case there is no evidence that the previous information provided by Sergeant Curran that Mrs Richards usually required the toilet when she was agitated was considered by Dr Barton. Screaming is a well-described behavioural disturbance in dementia (Dr Barton was clearly aware of this), which can be due to pain but is often not. In some cases it is not possible to identify a clear precipitating cause although a move to a new ward could precipitate such a behavioural disturbance. I would consider the assumption by Dr Barton that Mrs Richards screaming was due to pain was not supported by her own recorded observations. There is no evidence from the notes that Dr Barton examined Mrs Richards in the first two days to find any evidence on clinical examination that pain from her hip was the cause of her screaming. If the screaming had been worse on weight bearing or movement of the hip this would have provided supportive evidence that her screaming was

due to hip pain. Staff Nurse Jennifer Brewer in her interview with DC Colvin and DC McNally states that the nursing staff had considered the need for toileting and other potential causes of Mrs Richards screaming.

2.21 Mrs Richards pain following surgery had been controlled at Haslar hospital by intermittent doses of intravenous morphine and then intermittent doses of cocodamol (paracetamol and codeine phosphate). Dr Barton did not prescribe cocodamol or another mild or moderate analgesic to Mrs Richards to take on a prn basis when she was transferred. This makes me consider it probable that Dr Barton prescribed prn Oramorph, diamorphine, hyoscine and midazolam when she first saw Mrs Richards and she was not in pain. If this is the case it is highly unusual practice in a patient who has been transferred for rehabilitation, was not taking any regular or intermittent analgesics for 36 hours prior to transfer, and had last taken two tablets of cocodamol. In a rehabilitation or continuing care ward without resident medical staff I would consider it reasonable and usual practice to prescribe a mild or moderate analgesic to take on an as required basis in case further pain developed. In Mrs Richards's case a reasonable choice would have been cocodamol since she had been taking this a few days earlier without problems. I do not consider it was appropriate to administer intermittent doses of oramorph to Mrs Richards before first prescribing paracetamol, non-steroidal anti-inflammatory drugs or mild opiate. It is not appropriate to prescribe powerful opiate drugs as a first line treatment for pain not clearly due to a fracture or dislocation to a patient such as Mrs Richards 12 days following surgery. Dr Barton'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.

2.22 The management of Mrs Richards when sustained a dislocation of her hip on 13th August was in my opinion sub-optimal. The hip dislocation most likely occurred following the fall from her chair at 1330h. The nursing notes suggest signs of a dislocation were noted at 1930h. If there was a delay in recognising the dislocation I would not consider this indicates poor care, as hip fractures and dislocations can be difficult to detect in patients who have dementia and communication difficulties. Mrs Richards suspected dislocation or fracture was discussed with the on-call doctor, Dr Briggs, who I would assume is a medical house officer. Given the concern about a fracture or dislocation I would judge it would have been preferable for her to b transferred to the orthopaedic ward that evening and be assessed by the orthopaedic team. I certainly consider the case should have been discussed with either the on call consultant geriatrician or the orthopaedic team. The benefits of transfer that evening in a patient where it was highly probable a fracture or dislocation were present would have been Mrs Richards could have received manipulation earlier the following morning and possibly that same evening, and that traction could have been applied even if reduction was not attempted.

2.23 Mrs Richards was found to have a dislocation of her right hip and this was manipulated under intravenous sedation the same day. Although she was initially unresponsive, most probably due to prolonged effects of the intravenous midazolam, 3 days later on 17th August she was mobilising and fully weight bearing and not requiring any analgesia. Although there are few medical note entries, the management at Haslar hospital during this period

appears to be appropriate and competent. Shortly after transfer back to Daedalus ward Mrs Richards again became very distressed. The nursing notes indicate there was an incorrect transfer by the ambulance staff of Mrs Richards onto her bed. Repeat dislocation of the right hip was reasonably suspected but not found on a repeat Xray. My impression is that this transfer may have precipitated hip or other musculoskeletal pain in Mrs Richards but that other causes of screaming were possible.

2.24 Intermittent doses of oral morphine were first administered to Mrs Richards, again without first determining whether less powerful analgesics would have been helpful. On 18th August Dr Barton suggested commencing subcutaneous diamorphine, haloperidol and midazolam. The diamorphine and midazolam had been prescribed 7 days earlier. An infusion of the three drugs was commenced later that morning and hyoscine was added on 19th August. Both Dr Barton's notes and the nursing notes indicate Mrs Richards was in pain, although it is not clear what they considered was the cause of the pain at this stage, having excluded a fracture or dislocation of the right hip. Dr Barton states in her prepared statement "... *it was my assessment that she had developed a haematoma or large collection of bruising around the area where the prosthesis had been lying while dislocated*".

2.25 Although there are no clear descriptions of Mrs Richard's conscious 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 also seems that she was not offered fluids or food and intravenous or subcutaneous fluids were not considered as an alternative. My interpretation is that this was most probably because medical and nursing staff were of the opinion that Mrs Richards were dying and that provision of fluids or nutrition would not change this outcome. In her prepared statement Dr Barton states "*As their mother was not eating or drinking or able to swallow, subcutaneous infusion of pain killers was the best way to control her pain.*" and "*I was aware that Mrs Richards was not taking food or water by mouth*". She then goes on to say "*I believe I would have explained to the daughters that subcutaneous fluids were not appropriate*".

Evaluation of drugs prescribed and the administration regimens

2.26 The decision to prescribe oral opiates and subcutaneous diamorphine to Mrs Richards initial admission to Daedalus ward was in my opinion inappropriate and placed Mrs Richards at significant risk of developing adverse effects of excessive sedation and respiratory depression. The prescription of oral paracetamol, mild opiates such as codeine or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen would have been appropriate oral and preferable with a better risk/benefit ratio. The prescription of subcutaneous diamorphine, haloperidol and midazolam infusions to be taken if required was inappropriate even if she was experiencing pain. Subcutaneous opiate infusions should be used only in patients whose pain is not controlled by oral analgesia and who cannot swallow oral opiates. The prescription by Dr Barton on 11th August of three sedative drugs by subcutaneous infusion was in my opinion reckless and inappropriate and placed Mrs Richards 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 effects 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 a high risk of producing respiratory depression or coma.

2.27 I consider the statement by Dr Barton "*my use of midazolam in the dose of 20mg over 24 hours was as a muscle relaxant, to assist movement of Mrs Richards for nursing procedures in the hope that she could be as comfortable as possible. I felt it appropriate to prescribe an equivalence of haloperidol to that which she had been having orally since her first admission.*" Indicates poor knowledge of the indications for and appropriate use of midazolam administered by subcutaneous infusion to older people. Midazolam is primarily used for sedation and is not licensed for use as a muscle relaxant. Doses of benzodiazepine that produce significant muscle relaxation in general produce unacceptable depression of conscious level, and it is not usual practice amongst continuing care and rehabilitation wards to administer subcutaneous midazolam to assist moving patients.

Quality and sufficiency of the medical records

2.28 The medical and nursing records relating to Mrs Richards admissions to Daedalus ward are in my opinion not of an adequate standard. The medical notes fail to adequately account for the reasons why oramorph and then infusions of diamorphine and haloperidol were used. The nursing records do not adequately document hydration and nutritional needs of Mrs Richards during her admissions to Daedalus ward.

Appropriateness and justification of the decisions that were made

2.29 There are a number of decisions made in the care of Mrs Richards 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.

Recorded cause of death

2.30 The recorded cause of death was bronchopneumonia. I understand that the cause of death was discussed with the coroner. A post mortem was not obtained and the recorded cause was certainly a possible cause of Mrs Richards's death. I am surprised the death certificate makes no mention of Mrs Richards's fractured neck of femur or her dementia. It is possible that Mrs Richards died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mrs Richards was at high risk of developing pneumonia because of the immobility that resulted following her transfer back to Daedalus ward even if she had not received sedative and opiate drugs. Bronchopneumonia can also occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia was possible. However given the rapid decline in

conscious level that preceded the development of respiratory symptoms (rattly chest) I would consider it more likely that Mrs Richards became unconscious because of the sedative and opiate drugs she received by subcutaneous infusion, that these drugs caused respiratory depression and that Mrs Richards died from drug induced respiratory depression and/or without bronchopneumonia resulting from immobility or drug induced respiratory depression. There are no accurate records of Mrs Richards respiratory rate but with the doses used and her previous marked sedative response to intravenous midazolam it is highly probable that respiratory depression was present.

Duty of care issues

2.31 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care to attempt to monitor Mrs Richards and to document the effects of drugs prescribed. In my opinion this duty of care was not adequately met. The prescription of diamorphine, midazolam and haloperidol was extremely hazardous and Mrs Richards was inadequately monitored. The duty of care of the medical and nursing staff to meet Mrs Richard's hydration and nutritional needs was also in my opinion probably not met.

Summary

2.32 Gladys Richards 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 Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Baron. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death. In my opinion it is likely the administration of the drugs hastened her death. There is some evidence that Mrs Richards was in pain during the three days prior to her heath and the administration of opiates can be justified on these grounds. However Mrs Richards was at high risk of developing pneumonia and it possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative and opiate drugs.

Arthur "Brian" CUNNINGHAM

Course of Events

3.1 Mr Cunningham was 79 years old when admitted to Dryad ward, Gosport Hospital under the care of Dr Lord. Dr Lord had assessed him on a number of occasions in the previous 4 years. A letter dated 2nd December 1994 from Dr Bell, Clinical Assistant, indicates Parkinson's disease had been diagnosed in the mid 1980s and that he was having difficulties walking at this time. In 1998 it was noted he had experienced visual hallucinations and had moved into Merlin Park Rest Home. His weight was 69Kg in August 1998. In July 1998 he was admitted under the care of Dr Banks, Consultant in Old Age Psychiatry to Mulberry Ward A and discharged after 6 weeks to Thalassa Nursing Home. He was assessed to have Parkinson's disease and dementia, depression and myelodysplasia. Dr Lord in a letter dated 1 September 1998 summarises her assessment of Mr Cunningham when she saw him on Mulberry Ward A on 27 August 1998 before he was discharged to Thalassa Nursing Home. At this time he required 1-2 people to transfer and was unable to wheel himself around in his wheelchair. She commented that more levodopa might be required but was concerned it would upset his mental state. She arranged to review him at the Dolphin Day Hospital.

3.2 On 21st September 1998 he was seen at the Dolphin Day Hospital by Dr Lord who recorded *'very frail, tablets found in mouth, offensive large necrotic sacral sore with thick black scar. PD - no worse. Diagnoses listed as sacral sore (in N/H), PD, old back injury, depression and element of dementia, diabetes mellitus –diet, catheterised for retention. Plan – stop codanthramer and metronidazole. looks fine. TCI Dyad today –aserbine for sacral ulcer – nurse on side – high protein diet – oramorph prn if pain. N/Home to keep bed open for next 3/52 at least. Pt informed of admission agrees. Inform N/Home Dr Banks and social worker. Analgesics prn.'* He was admitted to Dyad ward. An entry by Dr Baron on 21 September states *'make comfortable, give adequate analgesia. Am happy for nursing staff to confirm death.'* On 24th September Dr Lord has written *'remains unwell. Son has ??? again today and is aware of how unwell he is. sc analgesia is controlling pain just. I am happy for nursing staff to confirm death.'* The next entry by Dr Brook is on 25th September *'remains very poorly. On syringe driver. For TLC'.*

3.3 Medication charts record the following administration of opiate and sedative drugs:

21 Sep 1415h Oramorph 5mg
1800h Coproxamol two tablets
(subsequent regular doses not administered)
2015h Oramorph 10mg
21 Sep 2310h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
22 Sep 2020h Diamorphine 20mg/24hr, midazolam 20mg/24hr infusion sc
23 Sep 0925h Diamorphine 20mg/24hr, hyoscine 200microg/24hr midazolam 20 mg/24hr infusion sc
2000h Diamorphine 20mg/24hr, hyoscine 200microg/24hr midazolam 60mg/24hr infusion sc
24 Sep 1055h Diamorphine 20mg/24hr, hyoscine 800microg/24hr midazolam 80mg/24hr infusion sc
25 Sep 1015h Diamorphine 60mg/24hr, hyoscine 1200mg/24hr

midazolam 80mg/24hr infusion
26 Sep 1150h Diamorphine 80mg/24hr, hyoscine 1200mg/24hr
midazolam 100mg/24hr infusion
Sinemet 110 5 times/day was discontinued on 23rd September

3.4 The nursing notes relating to the admission to Dyad ward record on 21st Sept '*remained agitated until approx 2030h. Syringe driver commenced as requested* (unclear who made this request) *diamorphine 20mg, midazolam 20mg at 2300. Peaceful following*". On 22nd Sep '*explained that a syringe driver contains diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode where Arthur tried to wipe sputum on a nurse saying he had HIV and going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself.*'

3.5 On 23rd Sep '*Has become chesty overnight to have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked is this was due to the commencement of the syringe driver and informed that Mr Cunningham was on a small dosage which he needed.*' A later entry '*now fully aware that Brian is dying and needs to be made comfortable. Became a little agitated at 2300h, syringe driver adjusted with effect. Seems in some discomfort when moved, driver boosted prior to position change*'. On 24th Sept '*report from night staff that Brian was in pain when attended to, also in pain with day staff – especially his knees. Syringe driver renewed at 1055*". On 25th Sept '*All care given this am. Driver recharged at 1015 –diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50mmols/hr. Peaceful night - unchanged, still doesn't like being moved.*' On 26th September '*condition appears to be deteriorating slowly*'.

3.6 On 26th September staff nurse Tubbritt records death at 2315h. Cause of death was recorded on the death certificate as bronchopneumonia with contributory causes of Parkinson's disease and Sacral Ulcer.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

3.7 Primary responsibility for the medical care of Mr Cunningham during his last admission lay with Dr Lord, as the consultant responsible for his care. She saw Mr Cunningham 5 days before his death in the Dolphin Day Hospital, and 2 days before his death on Dyad ward. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Cunningham and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

3.8 Initial assessment by Dr Lord was comprehensive and appropriate with a clear management plan described. The nursing staff record Mr Cunningham was agitated following admission on 21st September. Dr Lord had prescribed prn (intermittent as required) oramorph for pain. Nursing staff made the decision to administer oramorph but there is no clear recording in the nursing notes that he

was in pain or the site of pain. The nursing entry on 22nd Sept indicates a syringe driver was commenced for 'pain relief and to allay anxiety. Again the site of pain is not states. My interpretation of the records is that the nursing staff considered his agitation was due to pain from his sacral ulcer. The medical and nursing teams view on the cause of Mr Cunningham's deterioration on 23rd September when he became 'chesty' are not explicitly stated, but would seem to have been thought to be due to bronchopneumonia since this was the cause of death later entered on the death certificate. The medical and nursing staff may not have considered the possibility that Mr Cunningham's respiratory symptoms and deterioration may have been due to opiate and benzodiazepine induced respiratory depression. The nursing staff filed to appreciate that the agitation Mr Cunningham experienced on 23rd Sept at 2300h may have been due to the midazolam and diamorphine. It was appropriate for nursing staff to discuss Mr Cunningham's condition with medical staff at this stage.

3.9 When Dr Lord reviewed Mr Cunningham on 24th September the notes imply that he was much worse that when she had seen him 3 days earlier. There is clear recording by Dr Lord that Mr Cunningham was in pain. The following day the diamorphine dose was increased three fold from 20mg/24hr to 60mg/24hr and the dose was further increased on 26th September to 80mg/24hr although the nursing and medical notes do not record the reason for this. The notes suggest that the nursing and medical staff may have failed to consider causes of agitation other than pain in Mr Cunningham or to recognise the adverse consequences of opiates and sedative drugs on respiratory function in frail older individuals.

Evaluation of drugs prescribed and the administration regimens

3.10 The prescription of oramorph to be taken 4 hourly as required by Mr Cunningham was reasonable if his pain was uncontrolled from cocodamol. I consider the decision by Dr Barton 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 Dr Lord that he should be prescribed intermittent (underlined instruction) doses of oramorph earlier in the day. I consider the undated prescription by Dr Baron of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr 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 Mr Cunningham. 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.

3.11 In my opinion it is doubtful the nursing and medical staff understood that when a syringe infusion pump rate is increased it takes an often appreciable effect of time before the maximum effect of the increased dose rate becomes evident. Typically the time period would be 5 drug half-lives. In the case of diamorphine this would be between 15 and 25 hours in an older frail individual.

Quality and sufficiency of the medical records

3.12 In my opinion the medical and nursing records are inadequate following Mr Cunningham's admission to Dryad ward. The initial assessment by Dr Lord on 21st September is in my opinion competent and appropriate. The medical notes following this are inadequate and do not explain why he was commenced on subcutaneous infusions of diamorphine and midazolam. The nursing notes are variable and at times inadequate.

Appropriateness and justification of the decisions that were made

3.13 An inappropriately high dose of diamorphine and midazolam was first prescribed. There was a failure to recognise or respond to drug induced problems. Inappropriate dose escalation of diamorphine and midazolam and poor assessment by Dr Lord. The assessment by Dr Lord on 21st September 1998 was thorough and competent and a clear plan of management was outlined. There is a clear note by Dr Lord that oramorph was to be given intermittently (PRN) for pain and not regularly. It is not clear from the medical and nursing notes why Mr Cunningham was not administered the regular cocodamol he was prescribed following the initial dose he received at 1800h following admission. It is good practice to provide regular oral analgesia, with paracetamol and a mild opiate, particularly when a patient has been already taking this medication and to use prn morphine for breakthrough pain. I consider the prescription by Dr Barton on admission of prn subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be unjustified, poor practice and potentially very hazardous. It is particularly notable that only hours earlier Dr Lord had written that oramorph was to be given intermittently and this had been underlined in the medical notes. There is no clear justification in the notes for the commencement of subcutaneous diamorphine and midazolam on the evening following admission. If increased opiate analgesia was required increasing the oramorph dose and frequency could have provided this. I would judge it poor management to initially commence both diamorphine and midazolam. 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.

3.14 I am concerned by the initial note entry by Dr Barton on 21st September 1998 that she was happy for nursing staff to confirm death. There was no indication by Dr Lord that Mr Barton was expected to die, and Dr Barton does not list the reason she would have cause to consider Mr Cunningham would die within the next 24 hours before he was reviewed the following day by medical staff. In my opinion it is of concern that the nursing notes suggest the diamorphine and midazolam infusions were commenced because of Mr Cunningham's behaviour recorded in the nursing entry on 22nd September.

3.15 Hyoscine was commenced on 23rd September after Mr Cunningham had become 'chesty' overnight. I consider it very poor practice that there is no record of Mr Cunningham being examined by a doctor following admission on 21st September, and a decision to treat this symptomatically with hyoscine appears to have been made by the medical staff. At this stage Mr Cunningham's respiratory signs are likely to have been due to bronchopneumonia or respiratory depression resulting in depressed clearance of bronchial secretions. A medical assessment was very necessary at this

stage to diagnose the cause of symptoms and to consider treatment with antibiotics or reduction in the dose of diamorphine and midazolam.

3.16 Again I consider it very poor practice that the midazolam was increased from 20mg/24hr to 60mg/24 hr at 2000h on 23rd September. There is no entry in the medical notes to explain this dose increase. The decision to triple the midazolam dose appears to have been made by a member of nursing staff as the nursing notes record "*agitated at 2300h, syringe driver boosted with effect*".

3.17 A medical assessment should have been obtained before the decision to increase the midazolam dose was made. At the very least Mr Cunningham's problems should have been discussed with on call medical staff. Mr Cunningham's agitation may have been due to pain, where increasing analgesia would have been appropriate, or hypoxia (lack of oxygen). If Mr Cunningham's agitation was due to hypoxia a number of interventions may have been indicated. Reducing the diamorphine and midazolam dose would have been appropriate if hypoxia was due to respiratory depression. Commencement of oxygen therapy and possibly antibiotics would have been appropriate if hypoxia was due to pneumonia. Reducing the dose diamorphine or midazolam would have been indicated if hypoxia was due to drug-induced respiratory depression. The decision to increase the midazolam dose was not appropriately made by the ward nursing staff without discussion with medical staff.

3.18 When Mr Cunningham was reviewed by Dr Lord on 24th September he was very unwell but there is not a clear description of his respiratory status or whether he had signs of pneumonia. At this stage Dr Lord notes Mr Cunningham is in pain, but does not state the site of his pain. It is not clear to me whether the subsequent alteration in infusion rate of diamorphine, hyoscine and midazolam was discussed with and sanctioned by Dr Lord or Dr Barton. I consider the increase in midazolam from 60mg/24 hr to 80mg/24 hr was inappropriate as a response to the observation that Mr Cunningham was in pain. It would have been more appropriate to increase the diamorphine dose or even consider treatment with a non-steroidal anti-inflammatory drug. The increase in midazolam dose to 80mg/24 hr would simply make Mr Cunningham less conscious than he already appears to have been (there is not a clear description of his conscious level at this stage).

3.19 The increase in hyoscine dose to 800microg/24 hr is also difficult to justify when there is no record that the management of bronchial secretions was a problem. The subsequent threefold increase in diamorphine dose later that day to 60mg/24 hr is in my view very poor practice. Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death. The description of Mr Cunningham, was that analgesia was 'just' controlling pain and a more cautious increase in diamorphine dose, certainly no more than two fold, was indicated with careful review of respiratory status and conscious level after steady state levels of diamorphine would have been obtained about 20 hours later. A more appropriate response to deal with any acute breakthrough pain is to administer a single prn (intermittent) dose of opiate by the oral or intramuscular route, depending on whether Mr Cunningham was unable to swallow at this time.

3.20 The increase in both diamorphine dose and midazolam dose on 26th September is difficult to justify when there is no record in the medical or nursing notes that Mr Cunningham's pain was uncontrolled. Although it is possible to accept the increase in diamorphine dose may have been appropriate if Mr Cunningham was observed to be in pain, I find the further increase in midazolam dose to 100mg/24hr of great concern. I would anticipate that this dose of midazolam administered with 80mg/24hr of diamorphine would be virtually certain to produce respiratory depression and severe depression of conscious level. This would be expected to result in death in a frail individual such as Mr Cunningham. I would expect to see very clear reasons for the use of such doses recorded in the medical notes.

3.21 I can find no record of Mr Cunningham receiving food or fluids following his admission on 21st September despite a note from Dr Lord that Mr Cunningham was to receive a 'high protein diet'. There is no indication in the medical or nursing notes as to whether this had been discussed, but given that Mr Cunningham was admitted with the intention of returning to his Nursing Home (it was to be held open for 3 weeks) I would expect the notes to record a clear discussion and decision making process involving senior medical staff accounting for the decision to not administer subcutaneous fluids and/or nasogastric nutrition once Mr Cunningham was commenced on drugs which may have made him unable to swallow fluids or food.

Recorded causes of death

3.22 The recorded cause of death was bronchopneumonia with contributory causes of Parkinson's disease and sacral ulcer. A post mortem was not obtained and the recorded causes were in my opinion reasonable. It is possible that Mr Cunningham died from drug induced respiratory depression without bronchopneumonia present or from the combined effects of bronchopneumonia and drug-induced respiratory depression. Mr Cunningham was at high risk of developing pneumonia even if he had not received sedative or opiate drugs, bronchopneumonia can occur as a secondary complication of opiate and sedative induced respiratory depression. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mr Cunningham's respiratory rate I would consider the recorded cause of death of bronchopneumonia as reasonable. Even if the staff had considered Mr Cunningham had drug-induced respiratory depression as a contributory factor, it would not be usual medical practice to enter this as a contributory cause of death where the administration of such drugs was considered appropriate for symptom relief.

Duty of care issues

3.23 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care to attempt to heal Mr Cunningham's sacral ulcer and to document the effects of drugs prescribed. In my opinion this duty of are was not adequately met and the denial of fluid and diet and prescription of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham's death.

Summary

3.24 In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer, Dr Barton and the ward staff appear to have considered Mr Cunningham 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 hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham 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.

ALICE WILKIE

Course of Events

4.1 Alice Wilkie was 81 years old when admitted under the care of Dr Lord, by her general practitioner on 31st July 1998 from Addenbrooke Rest Home to Phillip Ward, Department of Medicine for Elderly People, at the Queen Alexandra Hospital, Portsmouth. The general practitioner referral letter states "*This demented lady has been in this psychogeriatric care home for a year. She had a UTI early this week and has not responded to trimethoprim. Having fallen last night, she is not refusing fluids and is becoming a little dry*". The medical admitting notes record she was taking prozac (fluoxetine) syrup 20 mg once daily, codanthramer 5-10ml nocte, lactulose 10ml once daily zopiclone 1.875 or 3.75mg nocte and promazine syrup 25mg as required. On examination she had a fever and bilateral conjunctivitis but no other significant findings. The admitting doctor diagnosed a urinary tract infection and commenced intravenous antibiotics to be administered after a blood culture and catheter specimen of urine had been obtained. The following day DNR (do not resuscitate) is recorded in the notes. On 3rd August 1998 the medical notes record the fever had settled, that she was taking some fluids orally, was taking the antibiotic Augmentin elixir orally and receiving subcutaneous fluids. The notes then record (date not clear) that her Mental Test Score was 0/10 and Barthel 1/20 (indicating severe dependency). Mrs Wilkie was to be transferred to Daedalus NHS continuing care ward on 6th August 1998 with a note that her bed was to be kept at Addenbrooke Rest Home.

4.2 Following transfer on 6th August an entry in the medical notes states "*Transferred from Phillips Ward. For 4-6/52 only. On Augmentin for UTI*". Dr Lord writes on 10th August 1998 '*Barthel 2/20. Eating and drinking better. Confused and slow. Give up place at Addenbrooke's. R/V* (review) *in 1/12* (one month) *–if no specialist medical or nursing problems D* (discharge) *to a N/Home. Stop fluoxetine*'. The next entry is by Dr Barton on 21st August "*Marked deterioration over last few days. sc analgesia commenced yesterday. Family aware and happy*". The final entry is on the same day at 1830h where death is confirmed. The most recent record of the patient's weight I can find is 56Kg in April 1994.

4.3 The nursing notes, which have daily entries during her one week stay on Phillip ward note she was catheterised, was confused at times and was sleeping well prior to transfer. The nursing notes on Daedalus ward record "6/8/98 *Transferred from Philip ward QAH for 4-6 weeks assessment and observation and then decide on placement. Medical history of advanced dementia, urinary tract infection and dehydration*" and that she was seen by Dr Peters. The nursing assessment sheet notes *"does have pain at times unable to ascertain where"*. The nutrition care plan states on 6th August 1998 "*Due to dementia patient has a poor dietary intake*". And dietary intake is recorded between 12th August and 18th August but not before or following these dates. Nursing entries in the contact record state on 17th August 1998 "*Condition has generally deteriorated over the weekend Daughter seen- aware that mums condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain*". There is no entry in the notes on 20th August or preceding few days indicating Mrs Wilkie was in pain.

4.4 A nursing entry on 21st August 1998 at 1255h states "*Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free*". There are a number of routine entries in the period 6th August 1998 to death on 21st August 1998 in nutrition, pressure area care, constipation, catheter care, and personal hygiene. The nursing care plan records no significant deterioration until 21st August where it is noted death was pronounced at 2120h by staff nurse Sylvia Roberts. Cause of death was recorded as bronchopneumonia.

4.5 The drug charts records that Dr Barton prescribed as a regular daily review (not intermittent as required) prescription diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr all to be administered subcutaneously. The prescription is not dated. Drugs were first administered on 20th August, diamorphine at 30mg/24hr and midazolam 20mg/24hr from 1350h and then again on 21st August. Mrs Wilkie had not been prescribed or administered any analgesic drugs during her admission to Daedalus ward prior to administration of the diamorphine and midazolam infusions. During the period 16th-18th August she was prescribed and received zopiclone (a sedative hypnotic) 3.75mg nocte and co-danthramer 5-10ml (a laxative) orally.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

4.6 Primary responsibility for the medical care of Mrs Wilkie during her admission to Daedalus ward lay with Dr Lord, as the consultant responsible for her care. She saw Mrs Wilkie on 10th August 1998, 11 days prior to her death. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Wilkie and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

4.7 The initial diagnosis of a urinary tract infection and dehydration was reasonable and appears correct. Mrs Wilkie had a diagnosis of dementia, which there was clear evidence for. The entry by Dr Lord on 10th August 1998 provides a reasonable assessment of her functional level at this time, and a plan to review appropriate placement in one month's time. No diagnosis was made to explain the deterioration Mrs Wilkie is reported to have experienced around 15th August. There is no medical assessment in the notes following 10th August except documentation on 21st August 1998 of a marked deterioration. There is no clear evidence that Mrs Wilkie was in pain although she was commenced on opiate analgesics.

Evaluation of drugs prescribed and the administration regimens

4.8 No information is recorded in the medical or nursing notes to explain why Mrs Wilkie was commenced on diamorphine and hyoscine infusions. In my opinion there was no indication for the use of diamorphine and hyoscine in Mrs Wilkie. Other oral analgesics, such as paracetamol and mild opiate drugs could and should first have been tried, if Mrs Wilkie was in pain, although there is no evidence that she was. If these were inadequate oral morphine would have

been the next appropriate choice. From the information I have seen in the notes it appears the diamorphine and midazolam may have been commenced for non-specific reasons, perhaps as a non-defined palliative reasons as it was judged she was likely to die in the near future.

4.9 I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr to be poor practice and potentially very hazardous. I consider it poor and hazardous management to initially commence both diamorphine and midazolam in a frail elderly underweight patient with dementia such as Mrs Wilkie. 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.

Quality and sufficiency of the medical records

4.10 The medical and nursing records during her stay on Daedalus ward are inadequate not sufficiently detailed, and do not provide a clear picture of Mrs Wilkie's condition. In my opinion the standard of the notes falls below the expected level of documentation on a continuing care or rehabilitation ward. The assessment by Dr Lord on 10th August 1998 is the only satisfactory medical note entry during her 15 day stay on Daedalus ward.

Appropriateness and justification of the decisions that were made

4.11 As discussed above I do not consider the decision to commence diamorphine and hyoscine was appropriate on the basis of the information recorded in the clinical notes.

Recorded causes of death

4.12 There was no specific evidence that bronchopneumonia was present, although this is a common pre-terminal event in frail older people, and is often entered as the final cause of death in frail older patients. I am surprised the death certificate did not apparently refer to Mrs Wilkie's dementia as a contributory cause. It is possible Mrs Wilkie's death was due at least in part to respiratory depression from the diamorphine she received, or that the diamorphine led to the development of bronchopneumonia. However since there are no clear observations of Mrs Wilkie's respiratory observations it is difficult to know whether respiratory depression was present Mrs Wilkie deteriorated prior to administration of diamorphine and midazolam infusion, and in view of this, my opinion would be that although the opiate and sedative drugs administered may have hastened death, and these drugs were not indicated, Mrs Wilkie may well have died at the time she did even if she had not received the diamorphine and midazolam infusions.

Duty of care issues

4.13 Medical and nursing staff on Daedalus ward had a duty of care to deliver medical and nursing care, to monitor, and to document the effects of drugs prescribed to Mrs Wilkie. In my opinion this duty of care was not adequately met, the prescription of diamorphine and midazolam was poor practice and this may have contributed to Mrs Wilkie's death.

Summary

4.14 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. However Mrs Wilkie 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 and opiate drugs.

Robert WILSON

5.1 Mr Wilson was 75 years old man when he was admitted to Queen Alexandra Hospital on 22nd September 1998 after he sustained a proximal fracture of the left humerus. He was treated with morphine, initially administered intravenously and then subcutaneously. He developed vomiting. On 24th September he was given 5mg diamorphine and lost sensation in the left hand. On 29th September an entry in the medical notes states *"ref to social worker, review resus status. Not for resuscitation in view of quality of life and poor prognosis".*

5.2 On 7th October the notes record he was *"not keen on residential home and wished to return to his own home".* Dr Lusznat, Consultant in Old Age Psychiatry on 8th October 1998, saw him. Dr Lusznat's letter on 8th October notes that Mr Wilson had been sleepy and withdrawn and low in mood but was now eating and drinking well and appeared brighter in mood. His Barthel score was 5/20. Dr Lusznat noted he had a heavy alcohol intake during the last 5 years. At the time he was seen by Dr Lusznat her was prescribed thiamine 100 mg daily, multivitamins two tablets daily, senna two tablets daily, magnesium hydroxide 10 mls twice daily and paracetamol 1g four time daily. On examination he had mildly impaired cognitive function (Mini Mental State Examination 24/30). Dr Lusznat considered Mr Wilson might have developed an early dementia, which could have been alcohol related, Alzheimer's disease or vascular dementia. An antidepressant trazadone 50mg nocte was commenced. Dr Lusznat states at the end of her letter "*On the practical side he may well require nursing home care though at the moment he is strongly opposed to that idea I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged*". On 13th October the medical notes record a ward round took place, that he required both nursing and medical care, was at risk of falling and that a short spell in long-term NHS care would be appropriate. Reviewing the drug charts Mr Wilson was taking regular soluble paracetamol (1g four times daily) and codeine phosphate 30mg as required for pain. Between 8th and 13th October Mr Wilson was administered four doses of 30mg codeine. Mr Wilson's weight in March 1997 was 93Kg

5.3 On the 14th October Mr Wilson was transferred to Dryad Ward. An entry in the medical notes by Dr Barton reads "*Transfer to Dryad ward continuing care. HPC fracture humerus. needs help with ADL (*activities of Daily Living*), hoisting, continent, Barthel 7. Lives with wife. Plan further mobilisation".* On 16th November the notes record; '*Decline overnight with S.O.B. o/e ? weak pulse. Unresponsive to spoken work. Oedema ++ in arms and legs. Diagnosis ?silent MI, ? decreased __ function. ↑frusemide to 2 x 40mg om '.* On 17th October the notes record '*comfortable but rapid deterioration'.* On 18th October staff nurse Collins records death at 2340h. Cause of death is recorded as congestive cardiac failure.

5.4 Nursing notes state in the summary section on 14th October "*History of left humerus fracture, arm in collar and cuff. Long history of heavy drinking. LVF chronic oedematous legs. S/B Dr Barton. Oramorph 10mg/5ml given. Continent of urine – uses bottles*". On 15th October "*Commenced oramorph 10mg/5ml 4 hrly for pain in L arm. Wife seen by sis. Hamblin who explained Robert's condition is poor*". An earlier note states *"settled and slept well*". On 16th October "*seen by Dr Knapman an as deteriorated over night. Increase*

*frusemide to 80mgdaily. For A.N.C (*active nursing care*)*". Later that day a further entry states "*Patient very bubbly chest this pm. Syringe driver commenced 20mg diamorphine, 400mcgs hyoscine. Explained to family reason for driver*". A separate note on 16th October in the nursing care plan states "*More secretions – pharyngeal – during the night, but Robert hasn't been distressed. Appears comfortable*". On 17th October 0515h "*Hyoscine increased to 600mcgs as oro-pharyngeal secretions increasing. Diamorphine 20mg.*" Later that day a further entry states "*Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver reviewed at 15.50 s/c diamorphine 40mg, midazolam 20mcgs, hyoscine 800 mcgs*". A later note states "*night: noisy secretions but not distressing Robert. Suction given as required during night. Appears comfortable*". On 18th October "*further deterioration in already poor condition. Syringe driver reviewed at 14:40 s/c diamorphine 60mg, midazolam 40mg, hyoscine 1200mcg. Continues to require regular suction*".

5.5 The medication charts record administration of the following drugs:
14 Sep 1445h oramorph 10mg
2345h oramorph 10mg
16 Sep 1610h diamorphine 20mg/24 hr, hyoscine 400 microg/24hr subcutaneous infusion
17 Sep 0515h diamorphine 20mg/24hr, hyoscine 600 microg/24hr
1550h diamorphine 40mg/24hr, hyoscine 800 microg/24hr midazolam 20mg/24hr
18 Sep 1450h diamorphine 60mg/24hr, hyoscine 1200 microg/24hr midazolam 40mg/24hr
Frusemide was administered at a dose of 80mg daily at 0900h on 15th and 16th October. An additional 80 mg oral dose was administered at an unstated time on 16th October.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

5.6 Responsibility for the care of Mr Wilson during his admission to Dryad ward lay with Dr Lord as the consultant responsible for his care. My understanding is that day to day medical care was delegated to the clinical assistant Dr Barton and during the out of hours responsibility was with the on call doctor based at Queen Alexandra Hospital. Ward nursing staff were responsible for assessing and monitoring Mr Wilson and informing medical staff of any significant deterioration.

5.7 Dr Lusznat was responsible for assessing Mr Wilson and making further recommendations concerning his future care when he was seen at Queen Alexandra Hospital.

Accuracy of diagnosis and prognosis including risk assessments

5.8 Dr Barton assessed Mr Wilson on 14th October the day he was transferred to Dyad ward. There was a plan to attempt to improve his mobilisation through rehabilitation. There is no record of any significant symptomatic medical problems, in particular any record that Mr Wilson was in pain in the medical

notes. The nursing notes suggest Mr Wilson was prescribed oramorph for pain in his arm following his admission to Dryad Ward. He was prescribed paracetamol to take as required but did not receive any paracetamol whilst on Dryad Ward.

5.9 Mr Wilson deteriorated on 15th September when he became short of breath. The working diagnosis was of heart failure due to a myocardial infarct. I do not consider the assessment by the on call doctor of Mr Wilson was adequate or competent. There is no record of his blood pressure, clinical examination findings in the chest (which might have indicated whether he had signs of pulmonary oedema or pneumonia). In my opinion an ECG should have been obtained that night, and a Chest Xray obtained the following morning to provide supporting evidence for the diagnosis. Mr Wilson was admitted for rehabilitation not terminal care and it was necessary and appropriate to perform reasonable clinical assessments and investigations to make a correct diagnosis.

5.10 Following treatment Mr Wilson was noted to have had a rapid deterioration. The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion. In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued. The nursing and medical staff failed to record Mr Wilson's respiratory rate, which was likely to have been reduced, because of respiratory depressant effects of the diamorphine. The diamorphine and hyoscine infusion should have been discontinued to determine whether this was contributing to his deteriorating state. There is no record of the reason for the prescribing of the midazolam infusion commenced the day before his death. At this time the nursing notes record he was comfortable. Mr Wilson did not improve. The medical and nursing teams did not appear to consider that the diamorphine, hyoscine and midazolam infusion could be a major contributory factor in Mr Wilson's subsequent decline. The infusion should have been discontinued and the need for this treatment, in my opinion unnecessary at the time of commencement, reviewed.

Evaluation of drugs prescribed and the administration regimens

5.11 The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate. His pain had been controlled with regular paracetamol and as required codeine phosphate (a mild opiate) prior to his transfer, and in the first instance these should have been discontinued.

5.12 I am unable to establish when Dr Barton wrote the prescription for subcutaneous diamorphine 20-200mg/24hr, hyoscine 200-800microg/24hr, and midazolam 20-80mg/24hr 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 Mr Wilson'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. Mr Wilson was not administered intravenous

frusemide or another loop diuretic. Instead only a single additional oral dose of frusemide was administered. In my opinion this was an inadequate response to Mr Wilson's deterioration. The prescription of continuous subcutaneous infusion of diamorphine and hyoscine is not appropriate treatment for a patient who is pain free with a diagnosis of a myocardial infarction and heart failure. When opiates are used to treat heart failure, close monitoring of blood pressure and respiratory rate, preferably with monitoring of oxygen saturation is required. This was not undertaken.

5.13 The increase in diamorphine dose to 40mg/24hr and then 60mg/24 hr in the following 48 hours is not appropriate when the nursing and medical notes record no evidence that Mr Wilson 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 40mg/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.

Quality and sufficiency of the medical records

5.14 The initial entry in the medical records by Dr Barton on 14th October is reasonable and sufficient. The subsequent entries relating to Mr Wilson's deterioration are in my opinion inadequate, and greater detail and the results of examination findings should have been recorded. No justification for the increases in diamorphine, midazolam and hyoscine dose are written in the medical notes. The nursing notes are generally of adequate quality but I can find no record of fluid and food intake by Mr Wilson.

Appropriateness and justification of the decisions that were made

5.15 I consider the prescription of oramorph was inappropriate. The subsequent prescription and administration of diamorphine, hyoscine and midazolam was highly inappropriate, not justified by information presented in the notes and could be expected to result in profound depression of conscious level and respiratory depression in a frail elderly man such as Mr Wilson.

Recorded causes of death

5.16 The recorded cause of death was congestive cardiac failure. The limited clinical information recorded in the absence of a chest Xray result or post-mortem findings, suggest this may have been the cause of Mr Wilson's death. However in my opinion it is highly likely that the diamorphine, hyoscine and midazolam infusion led to respiratory depression and/or bronchopneumonia and it is possible that Mr Wilson died from drug induced respiratory depression.

Duty of care issues

5.17 Medical and nursing staff on Dryad ward had a duty of care to deliver appropriate medical and nursing care to Mr Wilson, and to monitor the effects of drugs prescribed. In my opinion this duty of care was not adequate. The administration of high doses of diamorphine and midazolam was poor practice and may have contributed to Mr Wilson's death.

Summary

5.18 Mr Wilson 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 doses 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.

Eva PAGE

6.1 Eva Page was 87 years old when admitted as an emergency on 6th February 1998 to the Department of Medicine for Elderly People at Queen Alexandra Hospital. The medical notes record that she had experienced a general deterioration over the last 5 days was complaining of nausea and reduced appetite and was dehydrated. She had felt 'depressed' during the last few weeks. On admission she was taking ramipril 5mg once daily (a treatment for heart failure and hypertension), frusemide 40mg once daily (treatment for fluid retention), digoxin 125microg once daily (to control irregular heart rate), sotalol 40 mg twice daily (to control irregular heart rate), aspirin 75 mg once daily (to prevent stroke and myocardial infarction) and sertraline 50mg once daily (an antidepressant commenced by her general practitioner on 26th January 1998). A discharge summary and medical notes relating to an admission in May 1997 states that she was admitted with acute confusion, had reduced movement on the right side and was discharged back to her residential home on aspirin. No admitting diagnosis is recorded in the clerking notes written by Dr Harris on 6th February 1998 but they record that *"patient refuses iv fluids and is willing to accept increased oral fluids"*.

6.2 On 7th February 1998 the medical notes record an opacity seen on the chest Xray and sate *"mood low. Feels frightened – doesn't know why. Nausea and ??. Little else. Nil clinically."* An increased white cell count is noted (13.0) and antibiotics commenced. A subsequent chest Xray report (undated) states there is a 5cm mass superimposed on the left hilum highly suspicious of malignancy. The medical notes on 11 February 1998 record this at the Xray meeting. On 12th February 1998 the notes record (? Dr Shain) *'In view of advanced age aim in the management should be palliative care. Charles Ward is suitable. Not for CPR'.* On 13th February the notes record *'remains v low Appears to have 'given up' d/w son re probably diagnosis d/w RH (residential home) re ability to cope'.* The notes record *'son agrees not suitable for invasive Tx (*treatment*). Matron from RH visiting today will check on ability to cope.'*

6.3 On 19th February the notes record she fell on the ward and experienced minor cuts. On 16th February *'gradual deterioration, no pain, confused. For Charles Ward she could be discharged to community from Charles Ward'.* On 19th February the notes summarise her problems *'probable Carcinoma of the bronchus, previous left ventricular failure, atrial fibrillation, digoxin toxicity and a transient ischaemic attack, that she was sleepy but responsive, states that she is frightened but doesn't know why. Says she has forgotten things, not possible to elicit what she can't remember, low MTS (mental test score). Plan encourage oral fluids, s/c fluid over night if tolerated. Continue antidepressants'*. On 18th February the medical notes state *"No change. Awaiting Charles Ward bed"*.

6.4 The nursing notes record she was confused but mobilised independently. On 19th February she was transferred to Charles Ward instead of the preferred option of a bed at Gosport Hospital, which the notes record was full ('no beds'). The Queen Alexandra Hospital medical notes record a summary of her problems on 19th February prior to transfer as follows " *Diagnosis CA bronchus probable [no histology] Diag based on CXR. PMH 95 LVF + AF 95 Digoxin toxicity 97 TIA. Admitted 6.2.98 general deterioration CXR ? Ca Bronchus.*

Well defined O lesion. Exam: sleepy but responsive answers appropriately. States that she is frightened but doesn't know why. Says she has forgotten things. Not possible to elicit what she can't remember. Low MTS" and *"Feels in general tired and very thirsty. Plan encourage oral fluids, s/c fluid overnight is tolerated continue antidepressants".*

6.5 The medical notes on 23rd February record diagnoses of depression, dementia, ? Ca bronchus, ischaemic heart disease and congestive heart failure. On 25th February Dr Lord records in the medical notes "*confused and some agitation towards afternoon – evening try tds* (three times daily) *thioridazine, son in Gosport, transfer to Gosport 27/2, heminevrin prn nocte'.* A further entry states *'All other drugs stopped by Dr Lord'.*

6.6 Mrs Page was transferred to Dryad ward at Gosport War Memorial Hospital on 27th February 1998. Dr Barton writes in the medical notes "*Transfer to Dryad ward continuing care, Diagnosis of Ca Bronchus on 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 state she was admitted for '*palliative care'*, that she had a urinary catheter (inserted on 22nd February 1998) was incontinent of faeces, and was dependent for washing and dressing but could hold a beaker and pick up small amounts of food. Barthel Index was 2/20. The nursing action plan states '*encourage adequate fluid intake'.* On 28th February an entry in the medical notes by Dr Laing (duty GP) record '*asked to see: confused. Feels 'lost' agitated esp. night/evening, not in pain, to give thioridazine 25mg tds regular, heminevrin noct.* The nursing notes record she was very distressed and that she was administered thioridazine and Oramorph 2.5ml.

6.7 On 2nd March Dr Barton records '*no improvement on major tranquillisers. I suggest adequate opioids to control fear and pain; Son to be seen by Dr Lord today'.* A subsequent entry by Dr Lord on the same day states ' *spitting out thioridazine, quieter on prn sc diamorphine. Fentanyl patch started today. Agitated and calling out even when staff present (diagnoses) 1) Ca Bronchus 2) ? Cerebral metastases. -ct* (continue) *fentanyl patches.*' A further entry by Dr Lord that day records '*son seen. Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue present plan of Mx* (management)".

6.8 On 2nd March the nursing notes record "*commenced on Fentanyl 25mcg this am. Very distressed this morning seen by Dr Barton to have and diamorphine 5mg i/m (intramuscular) same given 0810h by a syringe driver.* A further entry the same day states "*S/B Dr Lord. Diamorphine 5mg i/m given for syringe driver with diamorphine loaded*". On 3rd March a rapid deterioration in Mrs Page's condition is recorded '*Neck and left side of body rigid – right side rigid,* At 1050h diamorphine and midazolam were commenced by syringe driver. Death is recorded later that day at 2130h, 4 days following admission to Dyad ward.

6.9 The prescription charts (which are incompletely copied in notes made available to me) indicate she received the following drugs during this admission Two doses of intramuscular diamorphine 5 mg were administered at 0800 and 1500h (date not visible)

28 Feb 1998	1300h thioridazine 25mg
	1620h oramorph 5mg
	2200h heminevrin 250mg in 5ml
1 Mar 1998	0700h thioridazine 25 mg
	1300h thioridazine 25 mg
	2200h heminevrin 250mg
2 Mar 1998	0700h thioridazine 25mg
	0800h fentanyl 25microg
3 Mar 1998	1050h diamorphine 20mg/24hr, midazolam 20 mg/24hr by subcutaneous infusion

On 27th February Dr Barton prescribed thioridazine 25mg (prn tds) and Oramorph (10mg/5ml) 4hrly prn. On 2nd March Dr Barton prescribed fentanyl 25microg patch (x3 days) to take as required (prn). On 3rd March Dr Barton prescribed diamorphine 20-200mg/24hr, hyoscine 200-800ucg/24hr and midazolam 20-80mg/24hr by subcutaneous infusion.
The notes do not indicate that the fentanyl patch was removed and I would assume this was continued when the diamorphine and midazolam infusion was commenced.

Opinion on patient management

Leadership, roles, responsibilities and communication in respect of the clinicians involved

6.10 Primary responsibility for the medical care of Mrs Page during her admission to Dryad Ward lay with Dr Lord, as the consultant responsible for his care. She saw Mrs Page 2 days before her transfer to Dryad ward and two days following her admission, the day before she died. My understanding is that day-to-day medical care was the responsibility of the clinical assistant Dr Barton and during out of hours period the on call doctor based at the Queen Alexander Hospital. Ward nursing staff were responsible for assessing and monitoring Mrs Page and informing medical staff of any significant deterioration.

Accuracy of diagnosis and prognosis including risk assessments

6.11 The assessment and management of Mrs Page at Alexandra Hospital was in my opinion competent and considered. From the information in the clinical notes I would agree with the diagnosis of probable carcinoma of bronchus. The decision to prescribe an antidepressant was in my opinion appropriate. Prior to transfer to Dryad ward she was not in pain but was transferred for palliative care. Although Mrs Page was clearly very dependent and unwell, it is not clear why Dr Barton prescribed opiates to Mrs Page on admission to Dryad ward when there is no evidence she was in pain. I suspect the reason was to provide relief for Mrs Page's anxiety and agitation. This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma. Mrs Page was noted to be severely dependent, Barthel Index 0, and in conjunction with a probable carcinoma of the bronchus the assessment that she required palliative care and was likely to die in the near future was appropriate.

Evaluation of drugs prescribed and the administration regimens

6.12 The prescription of the major tranquilliser thioridazine for anxiety was reasonable and appropriate. The prescribing of the sedative/hypnotic drug heminevrin was similarly reasonable although potential problems of sedation from the combination need to be considered. Mrs Page was not in pain but I consider the prescription of oramorph on 28th February to attempt to improve her distress was reasonable. By 2nd March Mrs Page remained very distressed despite prescription of Oramorph, thioridazine and heminevrin. Since the notes reported she was more settled following intramuscular diamorphine and she had been spitting out her oral medication, I would consider it appropriate to prescribe a transdermal fentanyl patch to provide continuing opioid drugs to Mrs Page. The lowest dose patch was administered but it would have been important to be aware of the potential for depression of respiration and/or conscious level that could occur.

6.13 I do not understand why subcutaneous diamorphine and midazolam infusions were commenced on 3rd March when Mrs Page had deteriorated whilst on the fentanyl patch. There is no indication in the notes that Mrs Page was in pain or distressed. The notes describe her as having undergone a rapid deterioration, which could have been due to a number of different causes, including a stroke or an adverse effect of the fentanyl patch. In my opinion the prescription by Dr Barton of subcutaneous diamorphine 20-200mg/24hr prn, hyoscine 200-800microg/24hr and midazolam 20-80mg/24hr was poor practice and potentially very hazardous. I would judge it poor management to initially commence both diamorphine and midazolam in a frail elderly underweight patient such as Mrs Page who was already receiving transdermal fentanyl. I would expect very clear reasons to support the use of the drugs to be recorded in the medical notes. The combination could result in profound respiratory depression and there are no symptoms recorded which suggest the administration of either drug was appropriate.

Quality and sufficiency of the medical records

6.14 The medical and nursing records relating to Mrs Page's admission to Dryad ward are in my view of adequate quality, although as stated above the reasons for the use of midazolam and diamorphine are not recorded in either the medical or nursing notes.

Appropriateness and justification of the decisions that were made

6.15 In my opinion the majority of management and prescribing decisions made by medical and nursing staff were appropriate. The exception is the prescription of diamorphine and midazolam on the day of Mrs Page's death. From the information I have seen in the notes it appears that Dr Barton may have commenced the diamorphine and midazolam infusion for non-specific reasons or for non-defined palliative reasons when it was judged she was likely to die in the near future.

Recorded causes of death

6.16 In the absence of a post-mortem the recorded cause of death is reasonable. Mrs Page had a probable carcinoma of the bronchus and experienced a slow deterioration in her general health and functional abilities. It is possible that Mrs Page died from drug induced respiratory depression. However Mrs Page was at high risk of dying from the effects of her probable carcinoma of the bronchus even if she had not received sedative and opiate drugs. Bronchopneumonia

can also occur as a complication of opiate and sedative induced respiratory depression but also in patients deteriorating from malignancy. In the absence of post-mortem, radiological data (chest Xray) or recordings of Mrs Page's respiratory rate I would consider the recorded cause of death was possible. The deterioration on between the 2nd March and 3rd March could have been secondary to the fentanyl patch she received but again could have occurred in the absence of receiving this drug. There are no accurate records of Mrs Page's respiratory rate but significant potentially fatal respiratory depression was likely to have resulted could have resulted from the combination of diamorphine, midazolam and fentanyl.

Duty of care issues

6.17 Medical and nursing staff on Dryad ward had a duty of care to deliver medical and nursing care, to monitor Mrs Page and to document the effects of drugs prescribed. In my opinion this duty of care was adequately met except during the last day of her life when the prescription of diamorphine and midazolam was poor practice and may have contributed to Mrs Wilkie's death.

Summary

6.18 Mrs Page 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 Dr Barton on the 3rd March. In my view this was an inappropriate, potentially hazardous prescription. I would consider it highly likely that Mrs Page 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.

Opinion on clinical management at Gosport War Memorial Hospital based on review of five cases presented by Hampshire Police

7.1 My opinion on the five cases I have been asked to review at Gosport War Memorial Hospital must be considered in context. My understanding is that the five cases have been selected by Hampshire Police because of concerns expressed relating to the management of these patients. Therefore my comments should not be interpreted as an opinion on the quality of care in general at Gosport War Memorial Hospital or of the general quality of care by the clinicians involved. My comments also relate to a period 2-4 years ago and the current clinical practice at the hospital may be very different today. An opinion on the quality of care in general at the hospital or of the clinicians would require a systematic review of cases, selected at random or with pre-defined patient characteristics. Examination of selected cases is not an appropriate mechanism to comment on the general quality of care of an institution or individual practitioners.

7.2 However having reviewed the five cases I would consider they raise a number of concerns that merit further examination by independent enquiry. Such enquiries could be made through further police interviews or perhaps more appropriately through mechanisms within the National Health Service, such as the Commission for Health Improvement, and professional medical and nursing bodies such as the General Medical Council or United Kingdom Central Council for Nursery, Midwifery and Health Visiting.

7.3 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 older 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 obstruction or where the patient does not wish to take regular medication (Appendix 2). In only one case were these criteria clearly fulfilled i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive doses 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 may have been routinely written up for many older frail patients admitted to Daedalus 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 Dr Lord's medical notes and her statement leads me to conclude 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 Dr Barton, were not adequate at the time these patients were admitted.

7.7 Having reviewed the five cases presented to me by Hampshire Police, I consider they raise serious concerns about nursing and medical practice on Daedalus and Dryad wards at Gosport War Memorial Hospital. In my opinion a review of practice at the institution is necessary, if this has not already taken place. I would recommend that if criminal proceedings do not take place, that these cases are brought to the attention of the General Medical Council and United Kingdom Central Council for Nursery, Midwifery and Health Visiting, in relation to the professional competence of the medical and nursing staff, and the Commission for Health Improvement, in relation to the quality of service provided to older people in the Trust.

APPENDIX 1

Pharmacology of Opiate and Sedative Drugs

Morphine

8.1 Morphine is a potent opiate analgesic considered by many to the 'drug of choice' for the control of acute pain (Therapeutic Drugs Dollery). Recommended starting dosage regimens for a fit adult of 70Kg are for intravenous bolus dosing 2.5mg every 5 min until analgesia achieved with monitoring of the duration of pain and dosing interval, or a loading dose of 5-15mg over 30min than 2,5mg – 5mg every hour. A standard reference text recommends 'morphine doses should be reduced in elderly patients and titrated to provide optimal pain relief with minimal side effects'. Morphine can be used for sedation where sedation and pain relief are indicated, Dollery comments '*it should be noted that morphine is not indicated as a sedative drug for long-term use. Rather the use of morphine is indicated where the requirement for pain relief and sedation coexist such as in patients admitted to intensive care units and other high dependency areas, the morphine dose should be titrated to provide pain relief and an appropriate level of sedation. Frequently other pharmacological agents (e.g.: benzodiazepines) are added to this regimen to increase the level of sedation".*

8.2 Diamorphine

8.3

8.4 **Fentanyl**

8.5 Fentanyl is a transdermal opioid analgesic available as a transdermal patch. The '25' patch releases 25microg/hr.

8.6 The British National Formulary (copy of prescribing in palliative care attached Appendix 2) comments on the use of syringe drivers in prescribing in palliative care that drugs can usually be administered by mouth to control symptoms, and that indications for the parenteral route are: patient unable to take medicines by mouth, where there is malignant bowel obstruction, and where the patient does not wish to take regular medication by mouth, It comments that staff using syringe drivers should be adequately trained and that incorrect use of syringe drivers is a common cause of drug errors.

Heminevrin

Midazolam

8.1 Midazolam is a benzodiazepine sedative drug. It is used as a hypnotic, preoperative medication, sedation for procedures such as dentistry and GO endoscopy, long-term sedation and induction of general anaesthesia. Iot is not licensed for subcutaneous use, but is described in the British National Formulary prescribing in palliative care section as 'suitable for a very restless patient: it is given in a subcutaneous infusion dose of 20-100mg/24 hrs.

8.2 DA standard text describes the use of sedation with midazolam in the intensive care unit setting, and states, "*sedation is most commonly met by a combination of a benzodiazepine and an opioid, and midazolam has generally replaced diazepam in this respect".* It goes on to state, "in critically ill patients, prolonged sedation may follow the use of midazolam infusions as a result of delayed administration". Potentially life threatening adverse effects are described, "Midazolam can cause dose-related CNS depression, respiratory and

cardiovascular depression. There is a wide variation in susceptibility to its effects, the elderly being particularly sensitive. Respiratory depression, respiratory arrest, hypotension and even death have been reported following its use usually during conscious sedation. The elderly are listed as a high-risk group; the elderly are particularly sensitive to midazolam. The dose should be reduced and the drug given slowly intravenously in a diluted form until the desired response is achieved. In drug interactions the following is stated. "*midazolam will also potentiate the central depressant effects of opioids, barbituates, and other sedatives and anaesthetics, and profound and prolonged respiratory depression might result.*

8.3

Hyoscine

8.4 The British National Formulary describes hyoscine hydrobromide as an antagonist (blocking drug) of acetylcholine. It reduces salivary and respiratory secretions and provides a degree of amnesia, sedation and antiemesis (antinausea). IN some patients, especially the elderly, hyoscine may cause the central anticholinergic syndrome (excitement, ataxia, hallucinations, behavioural abnormalities, and drowsiness). The palliative care section describes it as being given in a subcutaneous infusion dose of 0.6-2.4mg/24 hours.

8.5

Use of syringe drivers

8.1 The BNF states 'oral medication is usually satisfactory unless there is severe nausea and vomiting, dysphagia, weakness, or coma in which case parenteral medication may be necessary. In the pain section it comments the non-opioid analgesics aspirin or paracetamol given regularly will often make the use of opioids unnecessary. An opioid such as codeine or dextropropoxyphene alone or in combination with a non-opioid analgesic at adequate dosage may be helpful in the control of moderate pain id non-opioids are not sufficient. If these preparations are not controlling the pain, morphine is the most useful opioid analgesic. Alternatives to morphine are hydromoprhine, oxycodone and transdermal fentanyl. In prescribing morphine it states 'morphine is given as an oral solution or as standard tablets every 4 hour, the initial dose depending largely on the patient's previous treatment. A dose of 5-10mg is enough to replace a weaker analgesic. If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50% the aim being to choose the lowest dose which prevents pain. The dose should be adjusted with careful assessment of the pain and the use of adjuvant analgesics (such as NSAIDs) should also be considered. Although morphine in a dose of 5-10mg is usually adequate there should be no hesitation in increasing it stepwise according to response to 100mg or occasionally up to 500mg or higher if necessary. The BNF comments on the parenteral route '*diamorphine is preferred for injection. The equivalent intramuscular or subcutaneous dose of diamorphine is approximately a third of the oral dose of morphine'.*

8.2 In the chapter on pain relief in 'Drugs and the Older Person' Crome writes on the treatment of acute pain ' *treat the underlying cause and give adequate pain relief. The nature of the painful condition, the response of the patient and the presence of comorbidity will dictate whether to start with a mild analgesic or to go immediately to a more potent drug. In order to avoid the situation that patients remain in pain, "starting low" must be followed by regular re-evaluation with, if necessary, frequent increases in drug dose. The usual method of*

prescribing morphine for chronic pain is to start with standard oral morphine in a dose of 5-10mg every four hours. The dose should be halved in frail older people.

Prescribing for the Elderly

The British National Formulary states in Prescribing for the Elderly section "*The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, antipsychotics and antiparkinsonian drugs, all of which must be used with caution*".

Code A

28th May 2002

Mr M. Hudspith
General Medical Council
178 Great Portland Street
London W1W 5JE

Dear Mr Hudspith,

Mrs Gladys Richards

As progress is being made with your enquires regarding the conduct of medical staff at the Gosport War Memorial Hospital I wish the following concerns to be put on record.

When I approached the Gosport C.I.D. on 2 October 1998 I alleged a case of gross negligence manslaughter relating to the death of my mother, Mrs Gladys Richards. I quoted the points of law to be proved following Lord MacKay's ruling in 1995 concerning the case of Adomako. At that time I had not seen the medical files.

As you are aware the second investigation commencing in October 1999 revealed the contents of the files to me. I subsequently alleged a more serious situation as it appeared to me there was written indication of 'intent'. I am still of that opinion. The total disregard of Dr. Ian Reid's letter dated 5 August 1998 and the discharge letter from Haslar dated 10 August 1998 constitutes more than negligence. In addition the discharge note from Haslar dated 17 August 1998 indicates my mother was once more mobile. The medical files are now in your possession and you are aware of the grave issues raised. The P.C.A. upheld all my complaints relating to 'investigative failures' in the first investigation by Gosport C.I.D. I understand a similar situation has arisen relating to cases brought to the attention of police in 2001 and formal complaints have been lodged with the Chief Constable.

I am aware of the boundaries set for the G.M.C. and cases are not referred to the criminal court. However the patterns set in my mother's case and apparently followed in approximately nine other cases (to date) are such that I feel very strongly they should be dealt with in a Court of Law. A recent remark in a conversation with a police officer "Juries do not like to convict Doctors" says something of the intelligence of the average jury and the explanation of the law by an unbiased judge – let alone the Obiter Dicta by a Judge (Mars – Jones/Carr) (1986)

I hope your legal panel will bear this in mind and make recommendations accordingly before deciding on a hearing only before the G.M.C. I understand that a hearing would be open to the public with press coverage and this could bar a case being heard in the criminal court.

Yours sincerely

Code A

Gillian. M. MacKenzie

Copies:
RT Hon David Blunkett MP
Paul Kernaghan Chief Constable
Nigel Waterson MP Eastbourne
Peter Viggers MP Gosport
Duncan Geer PCA
Paul Close CPS London
David Parry Treasury Counsel

Tel. 01329-284661

Code A

28 June 2002

Mr M HUDSPITH
British Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr HUDSPITH,

WAR MEMORIAL HOSPITAL, GOSPORT

It has been brought to my attention that you are involved in an investigation into various members of the medical staff at the above hospital in late 1998, and feel you should be aware of the untimely death of my step-father in September of that year whilst under its care, if you do not know already.

My step-father was Arthur Denis Brian CUNNINGHAM, who was admitted into this hospital on 21 September with serious bed-sores, as outlined in various papers sent by me to the Hampshire Constabulary some considerable time ago. He died on 26 September, apparently from Bronchopneumonia.

For my own peace of mind, I would like you to take account of Mr CUNNINGHAM's case along with the others, and I will be pleased to assist your enquiries in any way possible. To this end, I would be readily available for a personal interview in your office during most of July and August, as I will be residing in London during that period.

I look forward to hearing from you.

Yours faithfully,

Code A

C R S FARTHING

Code A

11 April 2002

General Medical Council
178 Great Portland Street
London
W1W 5JE

Mr Michael Hudspith

FORMAL COMPLAINT

I am writing further to our recent telephone conversation with yourself regarding my mother Alice Wilkie's treatment at the Gosport War Memorial Hospital in August 1998.

I am completely dissatisfied with the sub-standard care that my mother received and her subsequent death on 21 August 1998. To summarise briefly the events which took place, my mother was taken from Addenbrooke Nursing Home on 31 July 1998 to Queen Alexandra hospital as a result of a Urinary Tract Infection. My mother stayed at Queen Alexandra for five days and appeared to be making good progress. Subsequently, she was sent to the Gosport War Memorial Hospital for assessment and rehabilitation.

At the Gosport War Memorial my mother appeared increasingly sleepy, weak and unwell, she couldn't stand or walk unaided. When I queried this with the ward sister I was simply told "yes, she was deteriorating". I was given no explanation as to why or what actions were being taken to help her. Just a few days later, I was called into Phillip Beed's office and was advised that my mother was dying and there was nothing that the hospital could do to help her. I thought this was strange at the time and was at not point given any explanation as to why this deterioration had taken place and why nothing could be done. I told Phillip Beed that I did not wish for my mother to suffer but that was the depth of our conversation at this time. There was no explanation of what actions would be taken with my mother and her care.

Whilst visiting on August 20th I noticed that my mother appeared to be in pain. When I mentioned this to the nursing staff they were dismissive and said that they could see no evidence of this. I had to ask twice and waited for over an hour before Phillip Beed came to see me. He did not examine my mother at this stage and did nothing to ascertain the level of pain she was in, but he did say he would arrange for some pain relief that would make her sleepy. I left the hospital at 13.55 and at this point nothing had been done to alleviate my mothers discomfort despite the fact that her notes state that she was placed on a syringe driver at 13:50. I had not left the hospital at this time so where has this discrepancy come from? I telephoned my daughter as I was very concerned about my mother and asked her to go to the Gosport War Memorial to find

out what was happening. When my daughter arrived, the nurse said to her in a very rude manner "your mother seems to think that your grandmother is in pain". By the time I returned to the hospital at eight o'clock that evening, my mother had been placed on a syringe driver administering Diamorphine drugs into her system. She was totally unconscious and never regained it. She died the next evening.

I have many questions that have never been answered regarding this. Why was my mother placed on Diamorphine via a syringe driver, when only that afternoon, the nursing staff appeared unaware and unconcerned that she was in any pain? Why were other drugs not tried first to relieve her discomfort and why was the Diamorphine administered in 30mg quantities? I believe that 5 to 10 mg's would be a normal dosage. I cannot understand why Diamorphine was used when no other drugs had been tried first. Why was no investigation done to find out where my mothers pain was and the cause of it. I suggest that it could have been a simple problem that could have been resolved with less severe pain relief.

Also, early on the morning of the 21st August a Lady came to my mothers bedside and merely stated "anytime now" before walking away. I recognised the lady as Dr Barton. She was very uncaring, rude and abrupt and did not bother to explain to myself or my daughters either who she was or what the current situation was regarding my mother. This is unacceptable and unprofessional on the part of Dr Barton.

I was persuaded to go home for some food and a change of clothes late in the afternoon of the 21st. I expressed my concern about leaving her to Phillip Beed as I did not wish for her to be alone. I was assured by Beed that should any change take place he would contact us immediately. However, when I returned a short while later Phillip Beed entered my mothers room in front of us and told us that she had just died. However, I do not believe that she died upon our return, but I believe that she died alone and had not been monitored in our absence. Phillip Beed told us that my mother had waited until she heard our voices before passing away, however, it was quite obvious that she had died much earlier than this. My mothers records state that her daughter and granddaughter were present at time of death, this is disputed by us and we know this was not the case.

I have now received my mother's medical file and am most distressed by it. The file itself appears to be incomplete and the details contained within it are sadly lacking to say the least. One of my main concerns is that in this file, there is a note from Phillip Beed stating that I had agreed for my mother to be placed on a syringe driver. I can categorically tell you that this 'alleged' conversation never took place. Also, there appears to be a mix up on the records of my mother and another patient Mrs Gladys Richards. A note stating that my mother was given Oramorph was crossed out with a note saying that this was written in error on the wrong notes. Also, the time of death on my mothers files says 18:30 and 21:20. How can she die twice? After speaking with Gladys Richards daughter she has confirmed that 21:20 is the time her mother passed away. This is gross incompetence on the part of the hospital and I wonder whether my mother was given these drugs in error or whether it was only written on her notes in error. The notes themselves are incomplete and there are whole days when nothing is written on them and there is no record of what, if anything, she was given to eat or drink. I would expect that if she had a UTI, was catheterised and

dehydrated then there should be a note of both her intake and her urinary output. This was done at Queen Alexandra but does not appear to be done at the Gosport War Memorial.

I would also like to know why my mothers notes state DNR on them without this being discussed with myself and also why her place at Addenbrooke was given up without my knowledge. After all the note from Queen Alexandra said that she was merely entering the War Memorial for rehab and assessment, she did not go there to die!!!

I am not prepared to let this matter lie. I believe that my mother died as a direct result of negligence on the part of the hospital and the administering of Diamorphine drugs which were not necessary. The death certificate states she died of Pneumonia but she showed no symptoms of this before dying and we were at no point advised of this condition. I am not happy that this case is being left and am pursuing the matter with the Police further as I believe that criminal acts have taken place. I will not rest until appropriate action has been taken against Dr Barton and Phillip Beed.

I look forward to hearing from you soon.

Yours sincerely

Mrs M Jackson

Code A

CC: Chief Constable Kernaghan – Hampshire Constabulary
Peter Viggers MP
David Blunkett MP
Iain Duncan Smith MP

Iain Wilson

Code A

COPY LETTER

18th May 2002

The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Sir,

Regarding the death of my Father Robert Caldwell Wilson at the Gosport War Memorial Hospital on 18th October 1998.

I wish to make a formal complaint against Dr Jane Barton and [redacted], who were I believe, responsible for my fathers care, administration of drugs and his death.

My father's death has been investigated by Hampshire police and by two medical experts, the information of their findings is in a secret report now held by Hampshire police.

I wish to be kept fully informed with regards this complaint and the eventual outcome.

If I can be of any further help please do not hesitate to contact me.

Yours sincerely

Code A

Iain Wilson.

Code A

Friday 17th May 2002

Tel: Home 02392 365555
Work 02392 584255
Ext. Code A

The Director
Mr Mike Hudspith
The General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Mr Hudspith

RE: GOSPORT WAR MEMORIAL - DEATH OF Mrs E I PAGE

I wish to make a formal complaint against two doctors working at The Gosport War Memorial in Gosport, Hampshire, during the time that my mother was in their care. The doctors concerned are [redacted] and Jane A BARTON (GP Code No. 3357406)

My mother was admitted from Queen Alexandra's Hospital, Portsmouth on 27th Feb 1998 and died the evening of the 3rd of March 1998.

The events leading up and including her death were investigated in a serious crimes investigation carried out by The Major Incident Complex, Portsmouth. Her case was serious enough to be sent to medical experts for opinion, I believe this report substantiates concern in her treatment. I also believe you have a copy and am aware of this case.

It is important to note that I was first made aware that there was concern in the treatment of elderly patients during 1998, when Mrs Gillian MacKenzies's case made local press news. At that time I wrote a letter to the police stating that I had concern relating to my mother, this was on the 9th April 2001. I was told that my mother's case would be investigated. I heard nothing until the 13 February 2002. At that time I was invited with other concerned relatives to a meeting with the head of the enquiry team who explained the events of the investigation and the reasons as to why no further action would be taken. At this meeting I first learnt that my mother's case was one of four cases investigated and expert opinions sought. I was also told at this meeting that these reports would be available to me. This promise was rescinded, and I was told later that Court Orders would be required, and this may well be refused.

I subsequently obtained my mothers notes and after perusal with a professional opinion, I found several grave areas of concern. I now understand from Mrs Ann Reeves (another unhappy relative) that these police reports were sent to you and you have/are investigating further.

I am annoyed that throughout this time I have been kept in the dark by the police as to any investigation made, and the investigating officers decision to take no further action, and his subsequent withdraw of the offer to release the medical opinions. I am presently making a formal complaint to The Chief Constable, Hampshire Police.

I trust you are able to assist me in this very serious matter.

Yours truly

Code A

Bernard Page

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A