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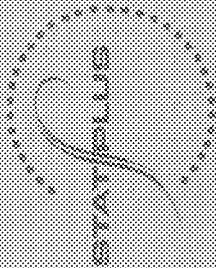

Not Proof of ID

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Nigel Niven
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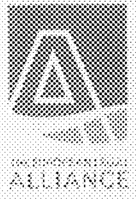
GMC100942-0002

GMC100942-0003

FIELD FISHER WATERHOUSE



BARTON:

PPC MINUTES

Field Fisher Waterhouse

					returned the gifts. The Committee was in no doubt that it is unprofessional to accept gifts of this value. It recognised that Mrs Breese was clearly very fond of the doctor, but questioned whether he was taking advantage of a vulnerable elderly patient. It noted that he had moved to a different practice by the time the gifts were received, but considered that this and the return of the goods does not negate the point that he behaved unprofessionally. It considered that the major issues that arose in this case could bring Dr Ghaharian's registration into question. Whilst at best his behaviour was foolish, naïve and ill-advised, at worst it could amount to inducing a vulnerable elderly lady to give him money and gifts, which could amount to spm if proved. The Committee noted that it was clear in GMP that doctors should not accept large gifts from patients, and determined that the case should be referred to the PCC. It asked however that we look at the charges, as we need to concentrate on the major issues – superfluous charges can weaken the case (i.e. charge 2f regarding the complainant's dog).
16.	**2001/2624**	**CHEUNG, E**			
17.	**2000/2047**	**BARTON, J A**	**Refer to PCC**	**CCPS**	The Committee initially was informed by the Committee Secretary that the case of patient Gladys Richards has been referred back to the CPS. It noted that the case related to five patients between the ages of 75–91 who were attending Gosport War Memorial Hospital, mainly for rehabilitation. One person (Mrs Lack) who was an experienced nurse in elderly care was concerned about the treatment of her elderly mother (Mrs Richards) in the ward, which precipitated the reviews of other patients. The Committee noted the fairly brief report of Dr Mundy, and Professor Ford's report which looked at all five cases. It noted the background to the case as a whole, which was that Dr Barton was a visiting clinical assistant who was responsible for the day-to-day management of these five cases. It noted that overwork had apparently affected patient care. It noted that in the case of Mrs Richards she had lost a hearing aid and her spectacles, and was

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					brought in in an agitated state, probably because of sensory deprivation. She became ambulant with a Zimmer, but her hip replacement became dislocated following a fall. This patient was prescribed the same set of drugs which was used in each of the other cases: Oramorph, hyoscine and midazolam. It noted that some patients had up to 60–80 mg in 24 hours via subcutaneous injection with a syringe driver. Patient Richards received no foods or fluids between 18 – 21 August and died because of the combination of lack of nutrition and sedation. The Committee considered that the administration of these drugs may have shortened the patient's life (which was not the same as suggesting that it killed her). Professor Ford says that the prescribing regime was variously reckless, excessive or highly inappropriate. It noted with concern that the medical records are not signed regarding the subcutaneous drugs regime. It noted the pattern in which an elderly group of patients, dealt with by a clinical assistant, were the subject of apparently reckless and inappropriate prescribing. Death appeared to have been precipitated if not caused by the drug regime in each case. The Committee noted that Dr Barton's post was supervised by a consultant, Dr Lord, who must therefore assume some responsibility for the events. It noted that palliative care is now a well-developed clinical area. If death is accelerated as a result of carefully titrated, good symptoms control, then as a side-effect it may be acceptable. This did not appear to be the case here, and the Committee was of the view that the matter unequivocally needs to be tested by the Professional Conduct Committee. Dr Barton moved patients very quickly onto a regime where they were receiving terminal care, and ignored the recommendations regarding doses in the BNF, rapidly prescribing excessive doses. It noted that there was a major public interest in the case. It asked that we look at charges 2 (b) ii) and iii) regarding Eva Page, as these would not raise an issue of spm (ask solicitors to look at charges). It noted that the case had been before the IOC which had made no order. The Committee considered that the case of Dr Lord should be screened if it hasn't already been. It further suggested that if the allegations against Dr Lord have already been screened, we might now have more information than the screener had at the time, and it may need to be re-screened. It considered that the nurses involved were open to criticism for withholding nutrition and for failing in their own whistle-

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					blowing responsibilities, and should be referred to the UKCC. It noted that there has already been a CHI report. The Committee noted that the documentation which was not included may contain information about the identity of the nurses concerned, and that a Nurse Philip Beed is named at p236. If we cannot identify other nurses we should ask the Trust for the names so they can be reported to the UKCC. We should also warn the press office about the case given the potential public interest, mentioning that other doctors and nurses might become involved. The Committee would like the case to be fast-tracked. Professor MacSween requested that a charge be added at 5 a. iii to reflect the inappropriate use of the word "happy" in the context of confirming death as this was at best inappropriate and reflected an attitude which caused considerable concern.
18.	**2001/3159**	**Radhakrishnan, S**	**No Further Action**	**CCPS**	The Committee noted the allegation that Dr Radhakrishnan prescribed Erythromycin to the patient, Miss Mangat, over the telephone, and may have allowed an earlier personal encounter with Miss Mangat's father to interfere with her clinical judgement. It was alleged that she did not want to make a home visit because she had had a row with Mr Mangat about planning permission. The Committee considered that there was no issue of spm or any chance of proving the charge in this case. There was nothing wrong with prescribing antibiotics over the phone or refusing to visit in certain circumstances, and the Committee took issue with the charges in this respect. It determined that we should take no further action. We should tell the complainant that doctors are entitled to decide whether or not to refuse to make a visit, say that this did not reach the threshold of spm, and explain the PPC's role.

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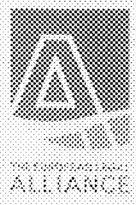

BARTON

PINK PAPERS

+ RULE 6 RESPONSE
+ IOC TRANSCRIPT

Fax

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

To	Judith C ritie Messrs Field Fisher Waterhouse
Fax number	020 7861 4356
From	Michael Keegan
Direct Dial	**Code A**
Direct fax	
No. of pages (inclusive)	29 *12:20*
Date	3 October 2002

Further to our telephone conversation, please find attached the MDU's response on behalf of Dr Barton to the PPC item.

178 Great Portland Street London W1N 6JE

AGENDA ITEM: 17
Confidential
(2002/2047) Barton, J
(continued from page 403)
'Explanation'

...icating with us about this matter

THE MDU
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

27th August 2002

FAO: Lorna Johnston
General Medical Council
178 Great Portland Street
London, W1

Code A

Code A

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 1973, 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 4 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.

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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.

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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

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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 - 200mgs over 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

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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.

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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.

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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

Code A

Ian S F Barker
Solicitor

Code A

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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.

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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.

H

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

A Yes.

T A Reed
& Co

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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

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

T A Reed & Co

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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.

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T A Reed & Co

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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—

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T A Reed
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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

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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.

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& Co

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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.

C

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

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

D

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

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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

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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

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Q If the nurses wished to move from one level of administration of opiate up to the 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.

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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,

F

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

Do you have a comment on that?

A I agree entirely. There was inadequate senior medical input.

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.

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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?

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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.

F

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.

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.

H

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

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

Q 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".
A There was no such thing in 2000. If your condition became medically stable and you could persuade social services to either fund you or agree to have you at all, then you would be moved on – even though your dependency score might be very low.

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

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

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

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.

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.

Q Could you say approximately how many times you raised these matters with people in lower management?

A Once every couple of months.

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.

Q These are including the 48 long-term care beds?

A We have long-stay elderly medical patients; we have babies; we have a maternity unit and we have a small GP ward.

Q Can you tell me roughly what the average length of stay was in, say, 1989, about 10 years ago, and then in the later part of the 1990s? How had the average length of stay changed?

A I had patients I had had for five years. I had some very ill patients transferred from the Royal Hospital, Haslar, after orthopaedic surgery or transferred from the main unit because they lived in Gosport and their relatives lived in Gosport. But those were the minority. The majority of patients were long stay.

Q Was there a calculation of the average length of stay in the early 1990s?

A It would be difficult to do, because we also did shared care and respite care in those days. I was looking at the figures the other day. You would find it very difficult to get a feel for the average length of stay, but it was generally reckoned to be a good long time. Then in the late 1990s – I could not find any research on this subject, but there are two major risk times for these elderly transferred from a nursing home to an acute unit and then down to a long-stay

A

...rit. 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.

T A Reed
& Co

43

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

T A Reed
& Co

431

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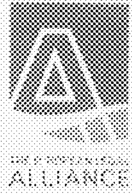
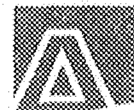
FIELD FISHER WATERHOUSE



BACTON :

CASE REPORTS .

Field Fisher Waterhouse



Case Report
September 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is part of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

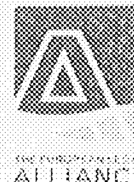
Listing time estimate: Unknown

Earliest date case may be listed: Unknown.

Conflict – we not sitting

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: Low/Medium/High**



Case Report
August 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

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Investigations:

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Recommendation:

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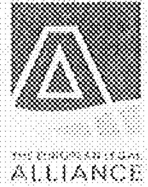
Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: Low/Medium/High**



Case Report
July 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date HS issued/FFW instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

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Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

The Constabulary are providing updates as to the progress of the investigation.

Recommendation:

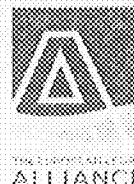
Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: ~~Low~~/Medium/~~High~~**



Case Report
June 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

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Investigations:

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Recommendation:

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Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~**Low**~~**/Medium/High**

Case Report
April 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	~~Michael Keegan~~ Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is part of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

The Constabulary are providing regular updates as to the progress of the investigation.

Recommendation:

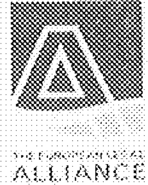
Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~**Low**~~**/Medium/**~~**High**~~



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Recommendation:

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Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~Low/Medium/High~~

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Case Report
March 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW instructed	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

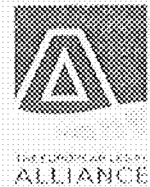
Listing time estimate: Unknown.

Earliest date case may be listed: Unkown.

Conclusions of Review Meeting:

Date of Next Review: Prospects of Success: Low/Medium/High

Next month please to report on police investigation – need idea on timing of police investigation



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Recommendation:

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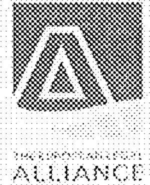
Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: Low/Medium/High**



Case Report
February 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daelalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that cannot prejudice the criminal enquiries.

Investigations

Meeting with case worker in order to provide an update as to the meeting with Hampshire Constabulary and the visit to the offices of the CHI.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: Low/Medium/High**

Case Report
January 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
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Date of Rule 6 letter:	11 July 2002
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Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that cannot prejudice the criminal enquiries.

Investigations

Visiting offices of CHI in order to work through documents and statements held by the organisation following their own investigation. This investigation did not focus on prescribing habits or Dr Barton's conduct.

Meeting with officers from Hampshire Constabulary to further discuss matter and to receive an update regarding the progress of the police investigation.

Recommendation:

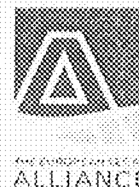
Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~Low~~/Medium/~~High~~



Case Report
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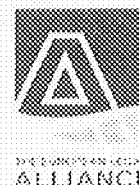
Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: Low/Medium/High**



Case Report

November/December 2002

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations

Lengthy meeting with officers from Hampshire Constabulary. Constabulary indicated the nature of the ongoing criminal enquiry had expanded beyond the five patients considered by the PPC. The investigations may include analysis of over 600 deaths. The officers informally requesting that the GMC stayed its proceedings pending the outcome of the criminal enquiries. Permission provided for FFW to visit CHI in order to review the documents held by the Commission but take no further action.

Visit arranged to review statements and papers held by CHI for 14/15 January 2003. Copies of a number of documents appearing in the appendices to the CHI report requested.

Recommendation:

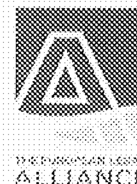
Review documents held by CHI and hold matter in abeyance until conclusion on the criminal enquiries.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: Low/Medium/High**



Case Report
October 2002

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW instructed:	23 September 2002
Class of Case (1-5)	Class 2
Target date for completion of investigation:	6 January 2003
Interim Order Expires:	N/A

Summary:
The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital. The allegations suggest that patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of five patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement.

Investigations

Chasing calls to Hampshire Constabulary requesting a meeting date and information regarding progress of police investigation.

Meeting arranged with DI Niven and colleagues.

Report prepared for GMC.

Letter to CHI prepared.

Recommendation:

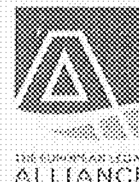
Determine determining status of police investigations and, if possible, contact relevant witnesses and retain expert.

Listing time estimate: 2-3 weeks.

Earliest date case may be listed: Matter provisionally listed for 7-25 April 2003.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: Low/Medium/High**



Case Report
September 2002

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed	23 September 2002
Class of Case (1-5)	Class 2
Target date for completion of investigation:	6 January 2003
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital. The allegations suggest that patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of five patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement.

Investigations

Papers considered by PPC analysed together with transcript of IOC hearing, documents relating to further complaints received at Screening Section and the Investigation report of CHI.

Case conference with the GMC.

Fax - and chasing fax – sent to Hampshire Constabulary requesting a meeting date and information regarding progress of investigations.

Recommendation:

Meet with Hampshire Constabulary.

Liaise with CHI regarding utilising aspects of their investigation – such as witness statements.

Contact relevant witnesses (after determining status of police investigations).

Retain expert.

Listing time estimate: 2-3 weeks.

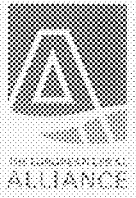
Earliest date case may be listed: Matter provisionally listed for 7-25 April 2003.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success: Low/Medium/High**

GMC100942-0052

FIELD FISHER WATERHOUSE



BACTON:
1999 COMPLAINTS

Field Fisher Waterhouse

GMC100942-0053

PH03

Fax

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

To Mr Matthew Lohn

Fax number 020 7488 0084

From Michael Keegan

Direct Dial Code A

Direct fax Code A

No. of pages (inclusive) 29 15:10

Date 27 September 2002

Please see attached letter.

Original posted to NSL 30/9

178 Great Portland Street London W1N 6JE

PHo3

Fax

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

To Mr Matthew Lohn

Fax number 020 7488 0084

From Michael Keegan

Direct Dial Code A

Direct fax Code A

No. of pages (inclusive) 29 15:10

Date 27 September 2002

Please see attached letter.

178 Great Portland Street London W1N 6JE

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax: 020 7915 3696

27 September, 2002

Also by fax: Code A

Mr Matthew Lohn
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Matthew

RE: DR JANE ANN BARTON

I wrote today to Judith Christie today enclosing copies of a letter dated 19 September 2002 with enclosures from Dr Simon Tanner at Hampshire and Isle of Wight Health Authority and my response of even date. You will not have received the same as yet and so I attach copies of all with this letter.

I have now been asked to obtain your written advice as to whether there is anything in the material received since the last IOC, or any other new factor not previously known when the IOC considered the case, which would justify referral of this matter back to the IOC once more. I should confirm that the letter of 19 September and enclosures amount to all the material received since the last IOC.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

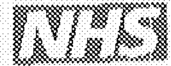
Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax:
Email: Code A

Enc.

c.c. Judith Christie
Field Fisher Waterhouse

GMC100942-0056

Hampshire and Isle of Wight
Health Authority 

Oakley Road
Southampton
SO16 4GX

Tel: 023 8072 5400
Fax: 023 8072 5466
Direct Dial: Code A

www.hiow.nhs.uk
Code A

STRICTLY CONFIDENTIAL

19 September 2002

For the Attention of

Vanessa Carroll
Conduct Section
General Medical Council
178 Great Portland Street
London
W1W 5JE

Dear Vanessa

Dr Jane Barton

I enclose a file of correspondence, which was passed to the management of Fareham and Gosport Primary Care Trust by a member of staff on Monday 16th September 2002.

I believe that the contents of the file have relevance to the ongoing enquiries at the General Medical Council.

If you have any queries about this, please contact me on Code A

Yours sincerely

Code A

Dr Simon Tanner
Director of Public Health/Medical Director

Chair: Peter Bingham
Chief Executive: Gareth Cruddace

GMC100942-0057

Syringe driver & Pain control courses attended.

Pain control and use of the Syringe driver
(L. Hester) 1 hour, 10/12/90.

Pain Management.
(Steve King) 2 hours, 20/8/91.

ENB 941 (Drug review – pain control, Article review – Use & Abuse of Syringe drivers. 1991 – 1992.

Psychological Aspects of care & Pain control
(E. Cole – Jubilee House) 1 day, 13/2/92.

RCN Palliative care update,
Sept 1992.

Administration of drugs in the community & community hosps.
(Miranda Knight & Barbara Robinson) 1 day, 7/3/94.

Palliative care group 'At a loss',
QAH 1 day, 7/11/94.

RCN UPDATE – ukcc Guidelines on drug administration & record keeping
½ day, 22/2/96.

Effective pain control & management
QAH Elderly med. 11/2 hours 27/11/98.

Syringe drivers & drug compatibilities

(Rhonda Cooper) 2 hours, 11/5/99.
Update into use of Opiates
(Dr Bee Wee) 1 hour, 26/8/99.

Palliative care issues including pain control
1 day, 12/5/00.

Summary of Meeting held at Redclyffe Annexe on 11.7.91

A meeting was arranged for the trained staff at Redclyffe Annexe following concern expressed by some staff at the prescribed treatment for 'Terminal Patients'

Present:

Mrs. Evans	
Sister Goldsmith	S/N Williams
Sister Hamblin	S/N Donne
S/N Giffin	S/N Tubbritt
S/N Ryder	S/N Barrington
S/N Barrett	E/N Turnbull

The main area for concern was the use of Diamorphine on patients, all present agreed to accept its use for patients with severe pain, but the majority had some reservations that it was always used appropriately at Redclyffe.

The following concerns were expressed and discussed:-

1. Not all patients given diamorphine have pain.
2. No other forms of analgesia are considered, and the 'sliding scale' for analgesia is never used.
3. The drug regime is used indiscriminately, each patients individual needs are not considered, that oral and rectal treatment is never considered.
4. That patients deaths are sometimes hastened unnecessarily.
5. The use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients needs.
6. That too high a degree of unresponsiveness from the patients was sought at times.
7. That sedative drugs such as Thioridazine would sometimes be more appropriate.
8. That diamorphine was prescribed prior to such procedures such as catheterization - where dizepam would be just as effective. [S [illegible] !]
9. That not all staffs views were considered before a decision was made to start patients on diamorphine - it was suggested that weekly 'case conference' sessions could be held to decide on patients complete care.
10. That other similar units did not use diamorphine as extensively.

Mrs. Evans acknowledged the staffs concern on this very emotive subject. She felt the staff had only the patients best interest at heart, but pointed out it was medical practice they were questioning that was not in her power to control. However, she felt that both Dr. Logan and Dr. Barton would consider staffs views so long as they were based on proven facts rather than unqualified statements. Mrs. Evans also pointed out that she was not an expert in this field and was not therefore qualified to condemn nor condone their statements, she did, however, ask them to consider the following in answer to statements made.

/...

1. That patients suffered distress from other symptoms besides pain but also had the right to a peaceful and dignified death. That the majority of patients had complex problems.

2. If 'sliding scale' analgesia was appropriate in these circumstances, particularly when pain was not the primary cause for patient distress. That terminal care should not be confused with care of cancer patients.

3. The appropriateness of oral treatment at this time considering the patients deterioration and possibility of maintaining ability to swallow. The range of drugs available to cover all patients needs in drugs that can be given rectally together with patients ability to retain and absorb product.

4. It was acknowledged that excessive doses or prolonged treatment may be detrimental to patients health but was there any proven evidence to suggest that the small amounts prescribed at Redclyffe over a relatively short period did in fact harm the patients.

5. It could be suggested to Dr. Barton that drugs could be given via a butterfly for the first 24 hrs. to give trained staff the opportunityto regularise dose to suit patient.

6. That treatment sometimes needed regularising as patients condition changed -were staff contributing signs of patients deterioration to effects of drug? Few patients remained aware until the moment of death.

7. What was the evidence to suggest that thioridazine or any other similar drugs would be better.

8. Again, what was the objection to diamorphine being used in this way and how was diazepam better.

9. Mrs. Evans wholly supported any system which allowed all staff to contribute to patients care however, she could not see that weekly meetings were appropriate in this case where immediate action needed to be taken if any action was required at all.

10. What was the evidence to prove that these other units care of the dying was superior to ours,before any change could be taken on this premis it would need to be established that we would be raising our standards to theirs rather than dropping our standards to theirs.

It was evident that no one present had sufficient knowledge to answer these questions with authority, it was therefore decided that before any critisism was made on medical practice we needed to be able to answer the following questions.

- What effect does Diamorphine have on patients.

- Are all the symptoms that are being attributed to Diamorphine in fact due to other drugs patients are recieving, or even their medical condition.

- Is it appropriate to give Diamorphine for other distressing symptons other than pain.

- Are there more suitable regimes that we could suggest.

/...

GMC100942-0060

To try and find the answers to these questions Mrs. Evans would invite Kevin Short to talk to staff on drugs and ask Steve King from Charles Ward Q.A. if he would be prepared to contribute to discussion.

This would take time to arrange meanwhile staff were asked to talk to Dr. Barton if they had any reason for concern on treatment prescribed as she was willing to discuss any aspect of patient treatment with staff.

I hope I have included everyones views in this summary, as we will be using it to plan training needs, please let me know if there is any point I have omitted or you feel needs amending.

IE/[illegible]
16.7 9[illegible]

GMC100942-0061

Confidential

REPORT OF A VISIT TO REDCLIFFE ANNEXE, GOSPORT WAR MEMORIAL HOSPITAL

AT 21.30 HOURS ON THURSDAY 31 OCTOBER 1991

BY

GERALDINE M WHITNEY, COMMUNITY TUTOR, CONTINUING EDUCATION

Purpose of Visit

The visit was in response to a request by Staff Nurse Anita Tubbritt to discuss the issue of anomalies in the administration of drugs.

Present

Staff Nurse Sylvia Giffin
Staff Nurse Anita Tubbritt
Enrolled Nurse Beverly Turnbull
Nursing Auxiliary Code A (Does not normally work at Redcliffe Annexe)
2 RGNs and 1 EN wished to but were unable to attend the meeting.

Background Information

The staff present presented the Summary of the Meeting held at Redcliffe Annexe on 11 July 1991 - appendix.

Problems Identified on 31 October 1991

1. Staff Nurse Giffin reported that a female patient who was capable of stating when she had pain was prescribed Diamorphine via syringe driver when she was in no obvious pain and had not complained of pain.

2. Staff Nurse Giffin reported that a male patient admitted from St Mary's General Hospital who was recovering from pneumonia, was eating, drinking and communicating, was prescribed 40 mg Diamorphine via a syringe driver together with Hyoscine, dose unknown, over 24 hours. The patient had no obvious signs of pain but had increased bronchial secretions.

3. Staff Nurse Tubbritt reported that on one occasion a syringe driver "ran out" before the prescribed time of 24 hours albeit that the rate of delivery was set at 50 mm per 24 hours.

4. The staff are concerned that Diamorphine is being prescribed indiscriminately without alternative analgesia, night sedation or tranquillisers being considered or prescribed.

6. Nurse Tubbritt reported that a female patient of 92 years awaiting discharge had i.m. 10 mg Diamorphine at 10.40 hours on 20.9.91. and a further i.m. 10 mg Diamorphine at 13.00 hours on 20.9.91. administered for either a manual evacuation of faeces or an enema.

6. There are a number of other incidents which are causing the staff concern but for the purposes of this report are too many to mention. The staff are willing to discuss these incidents.

7. It was reported by Staff Nurse Tubbritt that:

   a) 42 ampoules of Diamorphine 10 mg were used between 20 April 1991 - 15 October 1991.

   b) 57 ampoules of Diamorphine 30 mg were used between 15 April 1991 - 15 October 1991 (24 of the 57 ampoules of Diamorphine 30 mg were administered to one patient, who had no obvious pain, between 9 September 1991 and the 21 September 1991).

   c) 8 ampoules of Diamorphine 100 mg were used between 15 April 1991 - 21 September 1991 (4 of the 8 ampoules of Diamorphine 100 mg were administered to the patient identified in 7b above, between 19 September 1991 and the 21 September 1991).

   Note - This patient had previously been prescribed Oramorph 10 mg in 5 ml oral solution which was administered regularly commencing on 2 July 1991.

   The staff cannot understand why the patient was prescribed Oramorph and Diamorphine.

   When the staff questioned the prescription with Sister they were informed that the patient had pain. The staff recalled having asked the patient on numerous occasions if he had pain, his normal reply was no.

Conclusion

1. The staff are concerned that Diamorphine is being used indiscriminately even though they reported their concerns to their manager on 11 July 1991 (appendix).

2. The staff are concerned that non opioids, or weak opioids are not being considered prior to the use of Diamorphine.

3. The staff have had some training, arranged by the Hospital Manager, namely:

   - The syringe driver and pain control

   - Pain control

4. Staff Nurse Tubritt wrote to Evans the producers of Diamorphine and received literature and a video - Making Pain Management More Effective.

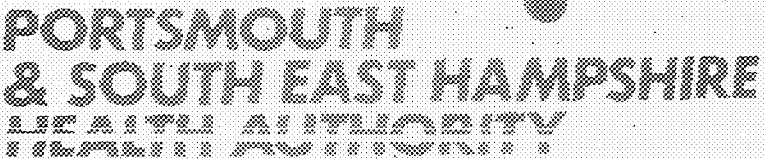
6. Staff Tunbritt is undertaking a literature on Pain and Pain Control.

Code A

Signed: .... Time: 23.35 hours

G M Whitney
Community Tutor, Continuing Education

Date: 31 October 1991



PORTSMOUTH
& SOUTH EAST HAMPSHIRE
HEALTH AUTHORITY

1.11.98

Anita,

Your meeting Sue Frost this pm.

Jarkers to check the Report. Will keep

you informed.

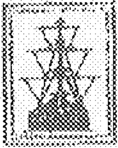
Code A

Northern Parade Clinic
Doyle Avenue
Hilsea
Portsmouth
PO2 9NF

Tel: Portsmouth (0705) 662378

With Compliments

GMC100942-0065



PORTSMOUTH & SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

COMMUNITY HEALTH CARE SERVICES

PORTSMOUTH CITY DIVISIONAL HEADQUARTERS
NORTHERN PARADE CLINIC
DOYLE AVENUE
PORTSMOUTH
PO2 9NF

Portsmouth (0705) 662378

Our ref: GMW/PGB Your ref: Please ask for...................................

4 November 1991

Mrs. Anita Tubbritt

Code A

Dear Anita

Report of a Visit to Redclyffe Annexe, 31.10.91

Herewith a copy of the above named report. I have given copies of the report to:

Mrs. Susan Frost, Principal Solent School of Health Studies, QAH.

Mr. W. Hooper, General Manager (West) Gosport War Memorial Hospital.

Mrs. I. Evans, Patient Care Manager, Gosport War Memorial Hospital.

Those who were present at the meeting.

I also wish to assure you of my support and help in this matter. Please do not hesitate to contact either Sue Frost or myself if you require any guidance.

Yours sincerely

Code A

Geraldine M. Whitney
Community Tutor, Continuing Education.

ENC.

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

COMMUNITY HEALTH SERVICES AND SMALL HOSPITALS UNIT

GOSPORT WAR MEMORIAL HOSPITAL
BURY ROAD,
GOSPORT,
HANTS, PO12 3PW
Gosport 524611 Ext. ....

Our ref: Your ref:

Dear S.N Tubbritt.

Thank you for your letter dated 31.10.91 informing me of the meeting that took place on 31.10.91 with Sysie Whitney at Redclyffe Annexe re the use of Diamorphine at Redclyffe Annexe.

May I take this opportunity to once more state that I am happy to discuss any areas of concern that staff may have, in fact I would welcome open discussion, [illegible] as I feel the only alternative is destructive criticism which achieves nothing positive and causes staff feeling frustrated

Yours Sincerely

Isobel Evans

GMC100942-0067

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

MEMORANDUM

FROM: Mrs. I. Evans
Patient Care Manager
Gosport War Memorial Hospital

TO: See Distribution

Your Ref.

My Ref. IE/LP

7th November 1991

It has been brought to my attention that some members of the staff still have concerns over the appropriateness of the prescribing of Diamorphine to certain patients at Redclyffe Annexe.

I have discussed this matter with Dr. Logan and Dr. Barton who like myself are concerned about these allegations. To establish if there is any justification to review practice we have agreed to look at all individual cases staff have or have had any concerns over and then meet with all staff to discuss findings.

I am therefore writing to all the trained staff asking for the names of any patients that they feel Diamorphine (or any other drug) has been prescribed inappropriately.

To ensure everyones views are considered I would appreciate a reply from every member of staff even if it is purely to state they have no concerns, by 21st November.

I am relying on your full co-operation and hope on this occasion everyone will be open and honest over this issue so we are able to address everyones concerns and hopefully resolve this issue in a constructive and professional manner.

Code A

I. Evans

Distribution

Every trained member of Staff at Redclyffe Annexe

copy to: Night Sister
Dr. Logan
Dr. Barton
Mr. Hooper

visited
Mrs Evans
to voice
22/11/91 9.30 am

P.T.

WESSEX REGIONAL OFFICE

General Secretary
Christine Hancock
BSc(Econ) RGN

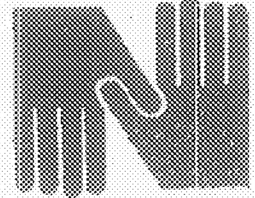
Patrons:
Her Majesty the Queen
Her Majesty Queen Elizabeth
the Queen Mother
Her Royal Highness
the Princess Margaret
Countess of Snowdon

8 Southgate Street
Winchester SO23 9EF
Telephone 0962 868332
Fax 0962 855819

SB/JTC

Gillian SC9139,
(K. Murray)

21 November 1991



Mrs I Evans
Patient Care Manager
Gosport War Memorial Hospital
Bury Road
Gosport
Hants
PO12 3PW

Dear Mrs Evans,

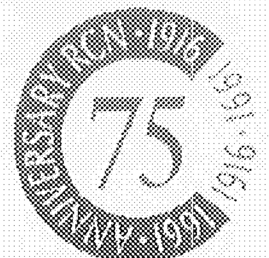
I refer to your memorandum to staff at Redclyffe Annexe dated 7th November 1991 and Keith Murray's letter to you dated 14th November 1991. I believe it is important that I reinforce the RCN's position as indicated to you in Mr Murray's letter.

This office was aware of the concerns that had been expressed by staff earlier this year and other discussions that had taken place with yourself as the Manager. It had been understood that the concerns raised would be addressed and the RCN had anticipated that clear guidance/policy would be promulgated as a result of the very serious professional concerns Nursing Staff were expressing.

It is now a matter of serious concern that these complaints were not acted upon in the way that had been anticipated and that Management are, some months after those discussions now seeking formal allegations. I would reinforce Mr Murray's position that this is not acceptable and the RCN is not prepared to be drawn into what could emerge as a vindictive witch hunt that would divide Nursing Staff, Medical Staff and Management. The complaints were adequately reported to Management earlier this year and you have received further evidence by way of Gerrie Whitney's report dated 31 October 1991. We now expect a clear policy to be agreed as a matter of urgency.

If it is not possible for Management to achieve this, the RCN will need to seek further instructions from its membership to pursue this matter through the grievance procedure on the basis that Management have failed to manage this situation properly.

Yours sincerely



Steve Barnes
RCN Officer - Wessex

c.c: Keith Murray

Headquarters
20 Cavendish Square
London W1M 0AB
Telephone 071-409 3333
Fax 071-355 1379

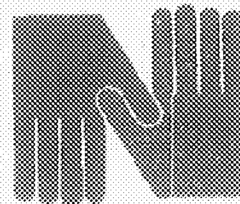
GMC100942-0069

General Secretary:
Christine Hancock
BSc(Econ) RCN

Patrons:
Her Majesty the Queen
Her Majesty Queen Elizabeth the Queen Mother
Her Royal Highness the Princess Margaret Countess of Snowdon

20 Cavendish Square
London W1M 0AB
Telephone 071 409 3333
Fax 071 355 1379

2nd December 1991



Anita Tubbritt,

Code A

Dear Anita,

Thank you for giving me the opportunity to speak to you over what I know is a very emotive and difficult subject.

As agreed at our meeting I have written to Chris West, District General Manager and enclosed a personal copy. I will keep you informed of any information as I receive it. I have spoken to Gerrie and also sent her a copy.

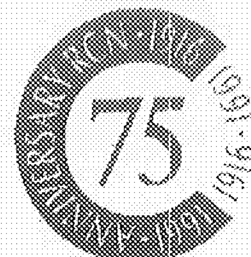
I would like to take the opportunity to reinforce the fact that you have the support of the RCN in this subject and if I can be of any more help please don't hestiate in contacting me.

With best wishes.

Regards,

Code A

enc.



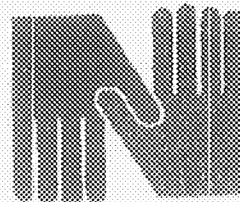
GMC100942-0070

General Secretary:
Christine Hancock
BSc(Econ) RGN

Patrons:
Her Majesty the Queen
Her Majesty Queen Elizabeth
the Queen Mother
Her Royal Highness
the Princess Margaret
Countess of Snowdon

20 Cavendish Square
London W1M 0AB
Telephone 071 409 3333
Fax 071 355 1379

2nd December 1991



Mr C West,
District General Manager,
District Offices,
St. Mary's Hospital,
Milton,
Portsmouth,
Hants. PO3 6AD

Dear Chris,

I am seeking your advice on how best to resolve a problem which was
brought to my attention in April 1991 but apparently has been present
for the last 2 years.

I was contacted by a staff nurse who is currently employed on night
duty in Redclyffe Annexe, her concern was that patients within
Redclyffe were being prescribed Diamorphine who she felt did not always
require it, the outcome being that the patient died. The drug was always
being administered via 'syringe drivers'. It is fair to say that this
member of staff was speaking on behalf of a group of her colleagues.

On my advice the staff nurse wrote to Isobel Evans, Patient Care
Manager putting forward her requirements under the UKCC Code of
Professional Conduct. Following this I had a meeting with Isobel Evans
Patient Care Manager on the 26th April 1991, the outcome of this was
that a 'policy' would be produced to specifically address the
prescribing and administration of controlled drugs within Redclyffe.
In addition a meeting would be held with the staff and Isobel where
they could voice their concerns, this meeting took place on the 11th
July 1991 and the minutes circulated, as these give a clear outline of
the concerns of the staff I have enclosed a copy for your perusal.

Following the aforesaid meeting two study days on 'Pain Control' were
arranged, as you will see from the minutes relating to the meeting of
the 11th July 1991 some of the concerns voiced by the staff were that
diamorphine was being prescribed for patients who were not in pain.
These study days did temporarily alleviate the worries of the staff.

Regrettably the concerns of the staff have once again returned, one of
the staff nurses who is currently on an ENB course was talking about
this subject to Gerrie Whitney, Community Tutor, Continuing Education.
Gerrie visited Redclyffe on the 31st October 1991 and subsequently
wrote a report. Copies of her report were circulated to Isobel, Bill
Hooper and Sue Frost, as I feel it is pertinent I have obtained Gerrie's
permission to enclose a copy.

GMC100942-0071

After receiving this report Isobel responded by sending a 'memo' (copy enclosed) to the trained staff at Redclyffe. As the 'concerns' had now apparently become "allegations" I wrote to Isobel voicing my concern on this point, also that she had to date not produced the policy to which we had agreed in April 1991. I also informed her that it was my view that unless I heard to the contrary a grievance would have to be lodged. To date Isobel has not responded.

I feel the staff have acted professionally and with remarkable restraint considering that it is fair to say that since highlighting their concerns there has been a certain amount of ostracisation. After talking to the staff and thinking it through I now feel that a grievance may not completely resolve this issue. I have been told that it is only a small group of night staff who are 'making waves', this could be true as a majority of the day staff have left over the period of 2 years that this situation has been present, whether this was a reason for their leaving I am unsure.

I have various concerns, for the patients and subsequently their relatives, the staff in that they are working in this environment but also that this could be leaked to the media. While none of the staff or myself have any desire whatsoever to use this means there is serious concern from both myself and the staff that someone could actually leak this and I hope you know my feelings about the media and using it as a means of resolving problems. On this basis alone I hope you agree with me in that we have to address this issue urgently.

As I stated at the beginning I am seeking your advice on what I think you will now feel is a difficult problem. I must stress that none of the staff have shown any malice in what they have said and that their only concern is for the patient.

Your comments/advice would be greatly appreciated.

Yours sincerely,

Code A

General Secretary:
Christine Hancock
BSc(Econ) RGN

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Her Royal Highness the Princess Margaret
Countess of Snowdon

20 Cavendish Square
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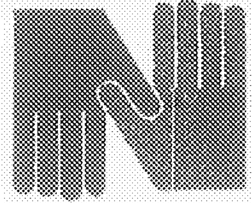
Fax 071 355 1379



2nd December 1991

Beverley Turnbull,

Code A

Dear Beverley,

Thank you for giving me the opportunity to speak to you over what I know is a very emotive and difficult subject.

As agreed at our meeting I have written to Chris West, District General Manager and enclosed a personal copy, I will keep you informed of any information as I receive it. I have spoken to Gerrie and also sent her a copy.

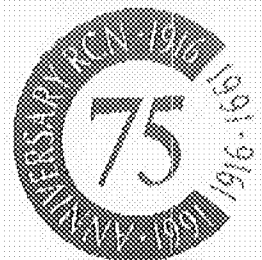
I would like to take the opportunity to reinforce the fact that you have the support of the RCN in this subject and if I can be of any more help please don't hestiate in contacting me.

With best wishes,

Regards,

Code A

enc.



PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

MEMORANDUM

FROM: Mrs. I. Evans
Patient Care Manager
Gosport War Memorial Hospital

TO: All trained Staff at Redclyffe

COPY to: Night Sisters
Mr. W. Hooper
Dr. Logan
Dr. Barton

Your Ref.

My Ref. IE/LP

5th December 1991

Due to the lack of response to my memo of the 7th November Dr. Logan will be unable to comment on specific cases, however, we have arranged a meeting for all members of staff at Redclyffe who have concerns on the prescribing of Diamorphine on Tuesday 17th December at 2 p.m. to discuss the subject in general terms.

It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have so I hope everyone will take the opportunity to attend and help resolve this issue.

Code A

I. Evans

General Secretary:
Christine Hancock
BSc(Econ) RGN

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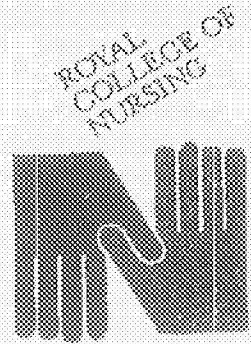


10th December 1991

Mrs I Evans,
Patient Care Manager,
Gosport War Memorial Hospital,
Bury Road,
Gosport,
Hants.,
PO12 3PW

Dear Mrs Evans,

I am receipt of a copy of the letter dated 5th December 1991 you have
sent to Mr B Barnes RCN Officer.

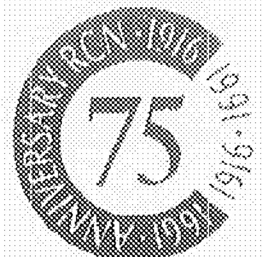
As far as I am aware it is not the use of syringe drivers that is the
cause of concern and I refer you to the minutes of the meeting that you
produced after your meeting of the 11th July 1991 with the staff.

I further note that you are holding a further meeting with the staff "to
once again re-address this problem". As you are fully aware of the
issues which are causing the concerns from the staff the purpose of
this meeting has to be doubtful. I refer you to the agreement following
our meeting on the 26th April 1991 which was that a policy would be
drawn up to address the issue of the concerns voiced by the staff. This
has failed to materialise.

I would reaffirm the position as stated in my letter 14th November 1991
and reiterated by Mr Barnes in his letter dated 22nd November 1991 the
serious concern in the lack of a positive response to what is
considered a perfectly reasonable request from staff who have acted
both professionally and with remarkable restraint. Furthermore that
some seven months have passed since this issue was first drawn to your
attention. Unless I receive a response in that a policy will be drawn up
which clearly addresses all the concerns is received from the staff
following your meeting I will be raising a grievance on behalf of the
staff.

Yours sincerely,

Code A



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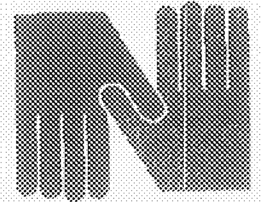


10th December 1991

Anita Dubarrett,

Code A

Dear Anita,

I enclose a copy of the letter I have sent Mrs Evans.

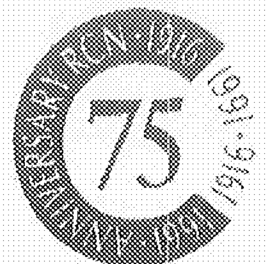
I think I have made it quite clear that unless you receive confirmation at your meeting that a policy will be drawn up which addresses all the concerns that you first brought to Mrs Evans attention back in July then a grievance will be lodged. If I hear from Chris West in the meantime I will naturally let you know immediately.

I hope my letter brings a positive response, the important thing at your meeting to remember is that you are the ones acting professionally and correctly, try to be assertive and don't be fobbed off. I will be thinking of you.

With best wishes.

Yours sincerely,

Code A



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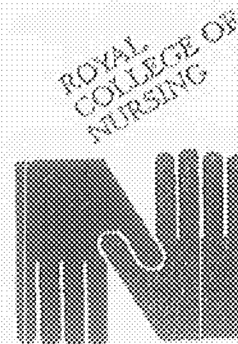

10th December 1991

Mrs I Evans,
Patient Care Manager,
Gosport War Memorial Hospital,
Bury Road,
Gosport
Hants.,
PO12 3PU

Dear Mrs Evans,

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sent to Mr B Barnes RCN Officer.

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cause of concern and I refer you to the minutes of the meeting that you
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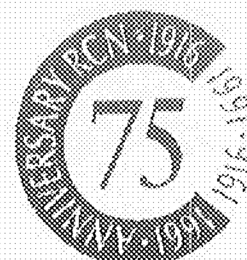

GMC100942-0077

General Secretary:
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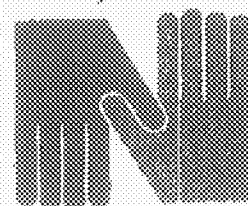
10th December 1991

Beverley Turnbull,

Code A



Dear Beverley,

I enclose a copy of the letter I have sent Mrs Evans.

I think I have made it quite clear that unless you receive confirmation at your meeting that a policy will be drawn up which addresses all the concerns that you first brought to Mrs Evans attention back in July then a grievance will be lodged. If I hear from Chris West in the meantime I will naturally let you know immediately.

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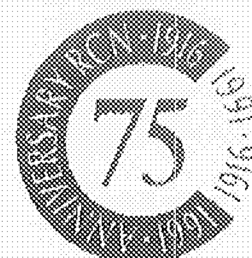
With best wishes.

Yours sincerely,

Code A



Notes of a Meeting held on Tuesday 17th December 1991 at Redclyffe Annexe for staff who had concerns related to the use of Diamorphine within the unit.

PRESENT

Mrs. Evans, Patient Care Manager
Dr. Logan, Consultant, Geriatrician
Dr. Barton, Clinical Assistant
Sister Hamblin
S.N. Jenne
S.N. Barrett
S.N. Giffin
S.N. Tubbritt
E.N. Bickfall
E.N. Turnbull

All trained staff were invited to the meeting if they were concerned with this issue, no apologies were received.

Mrs. Evans opened the meeting by thanking everyone for coming and highlighting the following:-

1. A staff meeting was held on 11th July 1991 to establish all staff's concerns re: the use of Diamorphine for terminal patients at Redclyffe Annexe.

2. A second meeting was held on 20th August where Steve King, Nurse Manager, Elderly Services Q.A.H. and Dr. Logan spoke to the staff on drug control of symptoms. The aim of this meeting was to allay staff's fears by explaining the reasons for prescribing. As no one challenged any statements at this meeting or raised any queries, it was assumed the problem had been resolved and no further action was planned.

   A recent report from a meeting held with Cerrie Whitney, Community Tutor, indicated some staff still had concerns, so a further meeting was planned for 17th December 1991.

3. Staff were invited to give details of cases they had been concerned over but no information was received, it was therefore decided to talk to staff on the general issue of symptom control and all trained staff would be invited to attend.

4. This issue had put a great deal of stress on everyone particularly the medical staff, it has the potential of being detrimental to patient care and relative's peace of mind and could undermine the good work being done in the unit if allowed to get out of hand. Everyone was therefore urged to take part in discussions and help reach an agreement on how to proceed in future.

5. Staff were asked to bear in mind that the subject was both sensitive and emotive and to make their comments as objective as possible.

/...

GMC100942-0079

As Mrs. Evans had presented staff's concerns she stated the problem as she saw it and invited staff to comment if they did not agree with her interpretation:-

1. We have an increasing number of patients requiring terminal care.

2. Everyone agrees that our main aim with these patients is to relieve their symptoms and allow them a peaceful and dignified death.

3. The prescribing of Diamorphine to patients with easily recognised severe pain has not been questioned.

4. What is questioned is the appropriateness of prescribing diamorphine for other symptoms or less obvious pain.

5. No one was questioning the amounts of Diamorphine or suggesting that doses were inappropriate.

All present agreed with these statements, no other comments were asked to be considered.

Mrs. Evans then reminded staff that at the July meeting it had been agreed that she neither had the authority or knowledge to write a policy on the prescribing of drugs, but she would be happy to talk to staff at the end of the meeting if any member of staff had concerns relating to the administration of drugs which was not amply covered by the District Drug Manual or U.K.C.C. Administration of Medicines. Dr. Logan then spoke to the staff at length on symptom control covering the following points:-

a. First priority was to establish cause of symptom and remove cause if possible.

b. Where appropriate the 'sliding scale' of analgesics should be used.

c. Oral medication should be used were possible and when effective (this raised the issue of the availability of Hyoscine as an oral preparation).

d. The aim of opiate usage was to produce comfort and tranquility at the smallest necessary dose - an unreceptive patient is not the prime objective.

e. The limited range of suitable drugs available if normal range of analgesics not effective.

f. That Diamorphine had added benefits of producing a feeling of well being in the patient.

g. The difficulty of accurately assessing levels of discomfort with patients who were not able to express themselves fully or who had multiple medical problems. The decision to prescribe for these patients had therefore to be made on professional judgement based on knowledge of patients condition, to enable patient to be nursed comfortably.

h. It was not acceptable for patients who are deteriorating terminally, and require 2 hrly turning, to have pain or distress during this process. They require analgesia even if they are content between these times.

/...

GMC100942-0080

Following general discussion and answering of staff questions Dr. Logan stated
he would be willing to speak to any member of staff who still had concerns
over prescribed treatment, after speaking to Dr. Barton or Sister Hamblin.
Comments raised during discussion were:-

(a) All staff had a great respect for Dr. Barton and did not question her professional judgement.

(b) The night staff present did not feel that their opinions of patients condition were considered before prescribing of Diamorphine.

(c) That patients were not always comfortable during the day even if they had slept during the night.

(d) There appeared to be a lack of communication causing some of the problem.

(e) Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms.

All staff agreed that if they had concerns in future related to the
prescribing of drugs they would approach Dr. Barton or Sister Hamblin in the
first instance for explanation, following which if they were still concerned
they could speak to Dr. Logan.

Mrs. Evans stated she would also be happy for staff to talk to her if they had any problems they wanted advice on.

With no further points raised, Dr. Barton, Dr. Logan, Sister Hamblin and S.N. Barrett left the meeting to commence Ward rounds.

Mrs. Evans spoke to the remaining nursing staff.

Staff were asked if they felt there was any need for a policy relating to
nursing practice on this issue. No one present felt this was appropriate.
Mrs. Evans stated she was concerned over the manner in which these concerns
had been raised as it had made people feel very threatened and defensive and
stressed the need to present concerns in the agreed manner in future.
She agreed with staff that there did seem to be a communication problem within
the unit, particularly between day and night staff which had possibly been
made worse by recent events. Mrs. Evans had already met with both the Day and
Night Sisters in an attempt to identify problem and she advised staff to go
ahead with planned staff meetings and offered to present staff's views from
both Day and Night staff if they felt this would be useful.
Mrs. Evans spoke to Sister Hamblin and S.N. Barrett the following morning to
ask them to organise day staffs views and ask them to make every effort to
ensure patients assessments were both objective and clearly recorded in
nursing records.

Mrs. Evans would arrange a further meeting with both Night Sisters and Sister
Hamblin following the staff meeting to ensure problems have been resolved with
information handover from Day to Night Staff and vice versa.

General Secretary:
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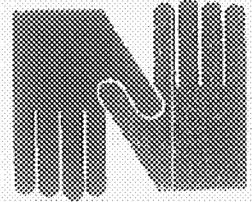


11th January 1972

Mrs A Tubbritt,
Code A

Dear Anita,

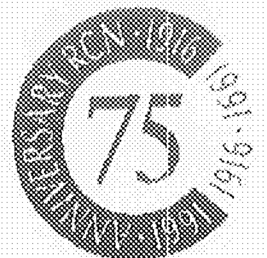
I have now heard from Chris West District General Manager, in his letter Chris has passed the situation onto Max Millett Unit General Manager. I was at a meeting with Tony Horne General Manager, Community Unit who informed me that he had already spoken to Bill Hooper about the concerns that I had put in my letter to Chris West. Tony will be getting back to me in due course. I hope this is clear!

I know that after your last meeting with Mrs Evans your concerns may be eleviated, I still feel that the underlying problem is still there. I therefore hope that you agree with allowing this to run the course.

With best wishes for 1992.

Yours sincerely,

Code A



GMC100942-0082

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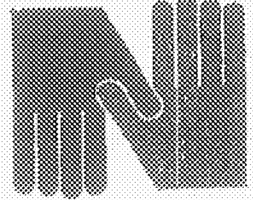

11th January 1992

Mrs Beverley Turnbull,

Code A

Dear Beverley,

I have now heard from Chris West District General Manager, in his
letter Chris has passed the situation onto Max Millett Unit General
Manager. I was at a meeting with Tony Horne General Manager, Community
Unit who informed me that he had already spoken to Bill Hooper about
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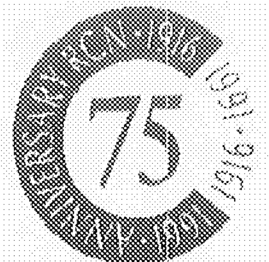

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

2? September, 2002

Ms Judith Christie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

RE: DR JANE ANN BARTON

Please find enclosed a letter dated 19 September 2002 with enclosures from Dr Simon Tanner at Hampshire and Isle of Wight Health Authority and my response of even date, both of which are self-explanatory.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax:
Email: Code A

78 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

Winmax Codes Grid

Gosport War Memorial Hospital

Trust Strategic
A1 leadership
A2 Accountabilities
A3 Direction & planning
A4 Health econ partnerships
A5 Patients & public partners

Service Strategic
B1 Leadership
B2 Accountabilities
B3 Direction & planning
B4 Service perf manage

Quality
C1 Staff Attitude
C2 Effectiveness & Outcome
C3 Access to services
C4 Organisation of care
C5 Humanity of care
C6 Environment
C7 Pos patient experience
C8 Neg patient experience

Staffing & Accountability
D1 Wrkfrc & serv planning
D2 Medical accountability
D3 Nursing accountability
D4 AHP accountability
D5 Other staff accountability
D6 Out of hours arrangements
D7 Team working
D8 Team working within a team
D9 Staff welfare
D10 Recruitment & retention
D11 Performance management

Guidelines
E1 Patient transfer
E2 DNR
E3 Palliative care
E4 Nutrition & Fluid
E5 Patient records
E6 Continence
E7 Trust perf management
E8 Consent
E9 Control of infection
E10 Rehabilitation
E11 Continuing care

Drugs
F1 Prescribing
F2 Administration
F3 Review
F4 Recording

Communication
G1 Patients
G2 Relative & Carers
G3 Primary Care
G4 Acute
G5 HA
G6 Haslar
G7 Social Services
G8 Nursing homes
G9 Joint Working

End of Life
H1 Patient care
H2 Relatives & carers
H3 Staff
H4 Cultural, spiritual needs
H5 Expectation of death

Supervision & Training
I1 Medical training
I2 Nursing
I3 AHP
I4 Other staff
I5 Induction
I6 Mandatory
I7 Joint training

Complaints
J1 Trust management
J2 Ward management
J3 Trust lessons
J4 Ward lessons
J5 Training

Clinical Governance
K1 Trust arrangement
K2 Ward arrangement
K3 PCT arrangement

NC No Code

Winmax Codes Grid

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B3 Direction & planning
B4 Service perf manage

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J3 Trust lessons
J4 Ward lessons
J5 Training

Clinical Governance
K1 Trust arrangement
K2 Ward arrangement
K3 PCT arrangement

NC No Code

Barton – Meeting with Hampshire Constabulary

Attendees:

GMC: Michael Keegan – MK

FFW: Judith Chrystie – JZC
John Offord – JHO

Police: DI Nigel Niven – NN
DS Owen Kenny – OK

Meeting

The attendees agreeing that JZC would make a brief minuted note of the meeting for circulation to all parties.

The parties introducing themselves and explaining their involvement in the case.

JZC explaining the situation within the GMC. Advising that the GMC would not proceed if NN indicated that to do so could prejudice any Police enquiry. JZC explaining the difference between running the case as a conviction matter and one in which we had to prove serious professional misconduct. JZC indicating the criminal rules of evidence were applied in GMC proceedings.

MK updating NN and OK as to the current position of the GMC enquiries. Indicating that the matter had both been screened and placed through the PPC.

JZC clarifying that the papers that the screener and the PPC had seen had been provided by Acting Detective Superintendent Burt. Noting that these papers had been forwarded through to the GMC when it appeared that the Police were no longer pursuing any criminal investigation. NN advising that when, in 1998/1999 concern was raised by the death of Gladys Richards, an investigation had taken place which the Police admitted was not as effective as it should have been. Advising that the CPS had considered the investigation and, in particular, the report prepared by Livesley on the Richard's case and had taken the view that causation could not be made out.

NN explaining that following the CPS's conclusion, the families of the elderly patients stated that they considered the Police had been too quick to conclude the matter and that as a consequence four other cases were "dip sampled" by a new Investigation Officer, Detective Superintendent James. Those other cases were considered by two alternative experts Ford and Munday.

NN indicating that the issue hinged on whether causation could be made out – and whether proving said causation may be outside of the investigations reach. NN added that a further file had been prepared for the CPS (by Supt. Stickler) and contained information on all five (above) cases. There were now a number of other incidents which still required a fuller investigation. NN indicating that on statistical analysis and a similar fact basis it may be possible to support/establish causation. Noting that there were significant arguments about the appropriateness of the prescribing regime and the instructions left by clinical staff. The

attendees noting that this was a particular issue for professional regulation given that it was not necessary to show that causation resulted in death merely of the inappropriateness of the prescribing regime amounted to bad practice.

NN advising that there were 50 other cases that the Police may consider. One of the issues that would have to be resolved was whether a policy decision should be made to look at the hundreds of individuals who had died at the Gosport War Memorial Hospital. Noting that from 1994 to the period in which Dr Barton resigned from the Hospital, there were around a thousand deaths, 600 of which had been certified by Dr Barton. There were further cases in which Dr Barton had provided the care although the death may have been certified by a different Practitioner.

Given the number of cases and the provisional views being provided by an alternative expert instructed by NN, Professor Robert Forrest, NN stating that he was increasingly moving towards the view to argue that causation could possibly be made out. NN noting, however, the difficulty in showing that death through bronchial illness of pneumonia was a consequence of diamorphine. Although it was noted that excessive diamorphine could cause respiratory difficulties, the victims were elderly patients who were, therefore, consequently vulnerable in any event.

NN emphasised that although there was a theme developing through the cases to suggest that Jane Barton may have relied on diamorphine and syringe drivers, the Police had an open mind as to whether any crime had been committed at all and if so, by whom. The investigation would consider the practices of other Practitioners working at Gosport Hospital. The attendees agreed that Jane Barton could not be the sole subject of any investigation.

JZC noting that the environment in which Dr Barton was working in which there were no prescribing policies may have allowed her to operate undetected.

OK identifying the fact that in 1991 concerns had been raised regarding the use of diamorphine by Junior Nurses /MK and JZC advising OK that these papers had been provided to the GMC but did not take the matter further in terms of the interim procedures. OK advising the circumstances in which the concerns had been made by the Junior Nurses and the fact that the Medical Practitioners and Senior Nurses had been opposed to any questioning of the clinical decision making. Noting that the fact that concerns had been raised some years previously did suggest that there was something may be amiss with Jane Barton's Practice over a period of years.

NN noting that there appeared to be a lack of motive. OK was continuing to look at this element.

NN advising that Liam Donaldson had asked Professor Baker to perform a statistical analysis of the GWMH issues. NN had raised the possibility of Professor Bakers work being expanded to enquire into Dr Barton's GP Practice. NN noting that Professor Baker's analysis of the statistics would take some time.

JZC advising that the GMC had the power to make an interim order suspending or placing conditions upon a Medical Practitioner's registration notwithstanding the fact that he or she had not been found guilty of serious professional misconduct. Stating that in this instance the IOC had determined not to place any interim order upon Dr Barton's registration. Noting that

this was based on a convincing argument by Dr Barton explaining the lack of resources and supervision and the poor conditions under which she had had to work. Stating that given that the Police were suggesting that there was potentially hundreds of deaths caused by Dr Barton and were actively assessing whether a murder charge could be prosecuted, JZC would be concerned to protect the patients and the public interest by presenting new evidence to an IOC Panel.

The parties discussing the disclosure requirements for GMC. Noting that the GMC would be forced to disclose any document which they wished to present to an IOC hearing in reliance of a request for an interim order.

NN appreciating the vulnerability of the GMC to criticism if a patient died at the hands of Dr Barton when the GMC could have taken action to prevent her from practising. He was, however, concerned regarding disclosure of material which he would not wish revealed to the Doctor at too early a stage. More importantly, any such action would have to be based on evidence. At this stage there was no new evidence other than the prevailing view as to the lack of causation now being potentially challengeable and the numbers of deceased patients being significantly expanded. NN stating that he was due to meet with the CPS to discuss the case, after which he foresaw that it would be possible for him to write a letter for the GMC indicating that Police investigations were continuing and that there were a minimum of 50 patients whose deaths would be analysed. The letter could possibly also advise that early medical advice suggested that the deaths may had been hastened by the prescribing regime provided by Dr Barton. The attendees agreeing that the letter from NN would also formally request that the GMC stay their proceedings.

JZC expressing concern that the defence could argue that Dr Barton was no longer working at Gosport War Memorial Hospital and, therefore, patients were not at risk from diamorphine prescriptions or syringe drivers. OK noting in this regard that Dr Barton's Private Practice would include elderly patients. JZC commenting that although she appreciated that it had not yet been determined whether the criminal enquiry should consider the Private/GP Practice, it would be helpful if the fact that investigations may be expanded in this direction could be included within the letter to the GMC. NN stating that whilst he would wish to assist the GMC as far as possible, it may be difficult for him to add this element to any letter. Noting that, whereas it would no doubt be of interest for Professor Baker to expand his analysis to include Dr Barton's Private Practice, this was not part of his specific remit established by Liam Donaldson. This matter was not yet clear.

NN advising that the letter to the GMC would also formally establish the Constabulary's commitment to liaise closely with the GMC. The parties agreeing that formal letters would be written outlining information that was possible for the GMC to disclose. There would also be contact through email, telephone and further meetings. JZC advising that she was likely to phone NN on a monthly basis so that she could report back to the GMC in her monthly reports.

The parties noting that Alexander Harris had expressed concern that the individuals involved in the various investigations and enquiries were not liaising. Noting the commitment to liaise closely could be articulated to Ann Alexander at Alexander Harris – it would, however, be necessary to stress the different role that each of the particular stakeholders were bound to adopt. Detail would not be provided about the level of communication or the information

being passed between the parties but Alexander Harris should be advised that formal channels of communication had been developed.

In this regard, NN advising that he had met with Ann Alexander last week. The meeting had been productive in that it had been on a non adversarial basis. Stating that Alexander Harris had used the media to generate publicity for the firm following the meeting. However, formal channels of communication had been established and it had been agreed that the family could raise concerns regarding any Police investigation through Alexander Harris. Hampshire Constabulary had also agreed to advise any new individuals that Alexander Harris were acting for some relatives; NN stressing that this would not be a referral service but merely informative.

NN stating that an important date was his meeting with the CPS scheduled for 28 November 2002. This meeting would establish the Constabulary's expectations as to the speed with which the CPS should consider the papers. NN advising that if the CPS/Police had any doubts about the matter it could be referred to Treasury Counsel. (An alternative Treasury Counsel to that which considered the initial referral of the Richard's case?).

OK querying whether the GMC had any record of Dr Barton's qualifications as he did not have a full history or CV. The GMC would attempt to track down as much information as possible.

The GMC also would pass on any Rule 6 response letter if appropriate. JZC also advising that the GMC had received two other complaints Carby and Batson. NN and OK did not recognise these names as individuals within the 50 cases being investigated by the Constabulary. JZC to pass the documents through to the Constabulary.

There appeared to be a culture of resorting to diamorphine care too quickly (perhaps for a easy life?). The parties identified the fact that there may be problems with other Doctors. MK advising NN and OK that the case against Lord had been "screened" within the GMC procedures and a decision taken not to pursue the matter.

As regards disclosure, JZC stating that she would work on the assumption that any documents provided by the Police would be undisclosable unless she was specifically advised otherwise in writing. JZC stating that the GMC enquiry, once it was permitted to proceed would, of course, have to disclose any documentation passed through by the Police. NN and OK appreciating this fact and noting at that stage, in any event, the Police enquiry would be concluded. NN stating that once the Police enquiry was concluded it would be possible to pass JZC all relevant documentation and, indeed, this was the basis on which the Police worked.

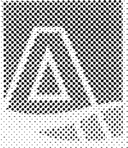
JZC explaining that we had received a report from CHI. She explained that we wished to obtain the documents that had been considered by the CHI investigation team and, moreover, visit CHI in order to analyse the witness statements taken. Stating that there would be no intention to interview the witnesses. NN agreeing that this would not prejudice any Police investigation and JZC and JHO could proceed with this aspect of the GMC enquiry.

The parties summarising the fact that NN would provide a letter to the GMC which could be used by the GMC in an IOC hearing, which would formally ask the GMC to stay their investigations and which would state that the parties were committed to regular liaison. (JZC

and MK noting that it may be difficult to persuade an IOC panel to place an interim order based only on a letter but identifying that this was the best position). NN advising that the Police would advise the GMC of any significant event and would release information if it was appropriate for them to do so.

GMC100942-0091

FIELD FISHER WATERHOUSE



DOCUMENTS
REC'D FROM GMC
re PREVIOUS CONCERNS

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

27 September, 2002

Ms Judith Chritie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

RE: DR JANE ANN BARTON

Please find enclosed a letter dated 19 September 2002 with enclosures from Dr Simon Tanner at Hampshire and Isle of Wight Health Authority and my response of even date, both of which are self-explanatory.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax:
Email: Code A

Your reference:

Our reference: 2002/1608

21 August 2002

First Class Post

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

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

Code A	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
Direct Line: Code A
Fax Line:
e-mail: Code A

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

Ref: RIR/cmp

29 August 2002

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

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

Complaint rec'd at period of care?

Farthing re Cunningham	Oct. '98	Dryad	On GMC list.
Code A	Nov. '98	Dryad	On GMC list.
Lack/McKenzie re Richards	Aug. '98	Daedalus	On GMC list.
Code A 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.

GMC100942-0098

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
Direct Line: Code A
Fax Line: 0[illegible]
e-mail: 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
Tel: Code A
Fax:
Email: Code A

Fareham and Gosport NHS
Primary Care Trust

Rec'd 1/10/02

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Code A

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.

GMC100942-0101

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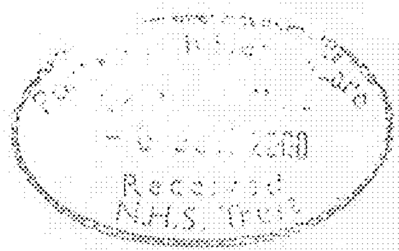


Code A

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.

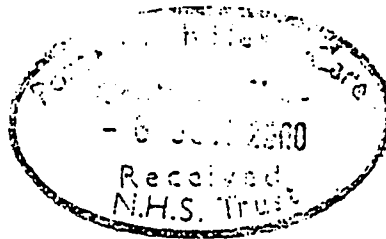
For ease and clarity I have taken the liberty of merely listing the problems, which we as a family encountered, my brother Michael is also in agreement to the sending of this letter: -

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 pa[illegible] er back and her legs; she has suffered from Osteo-Arthritis fo[illegible] any meetings with the medical team, it was mentioned that Ora[illegible] form of pain control. In truth my initial horror at the suggestion [illegible] orm of this strong medication was only assuaged by Dr Barton [illegible] was not only an excellent pain reliever but; enhanced heali[illegible] l 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

app(1)



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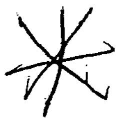
2. Pain Relief. Mother was indeed in a great deal of pain and discomfort with both her back and her legs; she has suffered from Osteo-Arthritis for many years. At the first of many meetings with the medical team, it was mentioned that Oral Morphine might be the best form of pain control. In truth my 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

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. <u>Why did Dryad ward offer different pressure sore advice to other areas</u>?

   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. <u>Dr. Barton's advice that morphine enhances healing, stimulates the appetite and is an efficient mood enhancer</u>

   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.

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.

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.

GMC100942-0111

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.

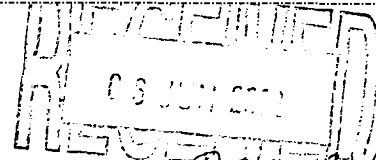
Yours sincerely,

Max Millett
Chief Executive

Silent copy to: Dr. I. Reid
[illegible] T. Cameron

C

MRS R. CARBY



The General medical Council
178 Great Portland Street
London
W1W 5JE

27th May 2002

FORMAL COMPLAINT

RECEIVED 06 JUN 2002

D.O.B 31/12/1933

Dear Sir

Regarding the death of my Husband Stanley Eric Carby, at the Gosport war memorial on 27th April 1999.

I wish to make a formal Complaint against DR. Jane Barton, Staff nurse JOICE, and other nurses on duty when my Husband was in there Care. my daughter and i went to a meeting at gosport war memorial on the 22nd may 2002 at 9.30, with a DR LORD and JAN PEACH. We went to view my Husbands medical notes, and to ask questions about the Concerns we have about the sudden death of my Husband. After the meeting we have decided that we are not Satisfied with the answer's they gave us. To which i have stated on another piece of paper the question's asked and the answer's given by DR LORD + JAN PEACH.

After looking through my Husbands medical notes I am disgusted the fact that none of his notes are filled out in the Correct procedure that they Should. The dates are incorrect on his admission. The notes are not timed when Checks was done on my Husband. And the drugs record, they have the wrong dates drugs was given. also drugs that were given, have been crossed, If drugs are Crossed out you must give reasons why in the exceptions to prescribed orders sheet. and if you take a look, this has not been done, no time, no date, no reason.

Formal Complaint Cont:

My Husband was given midazalam and morphine driver, in his notes they state this was given on the 27th april, So why does it state that he was given it on the 26th april at 12.15 in his drugs record.
I am disgusted in the way these medical notes have been done. By law medical notes should be timed, dated and signed, after each entry, and obviously this has not been done.
My Husband was moved to Gosport War Memorial on the 26th april and died 1.o.clock on the 27th april.
We only recieved a phonecall at 10.15 the morning of the 27th april to say that my Husband had a bad night and wasnt well, Could we go in. We arrived there at 10.30 to find my husband not able to speak, open his eyes, or move, he could only lie there in his bed. When we asked the nurse why wasnt we phoned earlier. we was told he only went like this at the time they phoned us.
But looking through his notes now, we can see he was like this early in the morning. If you take a look at the form called general information. you will notice that on there it states, "CONTACT AT ANY TIME IF CONDITION CHANGES"
So why was we not contacted sooner. The reason we were given by dr Lord + Jan peach was "we dont know"! "but all we can say is sorry" that is not acceptable my Husband would need us with him.
On his notes it states he was not alert and holding his head back, and in one statement it say's he is now unconscious and she was refering him to speach and language therapist. forgive me if I'm wrong but if someone is unconscious dont you get them to a Hospital where they can be seen to by a doctor. Who can give medical treatment. but instead they phoned Dr lord, who said give him midazalam, but they now say they did not give him midazalam.

(Formal Complaint Cont:
So is this what the nurses are allowed to do, they are instructed by a doctor to give midazalam, but they take no notice to this and not give it, I am very upset with the care my husband was given, we told the nurses that my husband can get agitated at times, and to call one of us in the family, and we will come and sit with him, to put him at ease, but no. still they did not tell us.
When DR Jane Barton arrived at the hospital she asked to see us, I then asked Dr Barton if my husband was going to make it through this, she replied let nature take its course, on the notes that S.N Joice wrote, she put that I said my husband wasn't going to make it, that is a complete lie. it also states that we thought he was in pain and asked for them to make him comfortable. This is all lies we wasn't told in anyway that he would be having a morphene driver as well as madazalam.
my family and I are very angry with these points I have told you, we have never been satisfied with the way my husband died so quickly after leaving Haslar, and to find his notes in such a mess just proves that this is complete negligence and we will not stop untill something is done.
thankyou for taking the time to read this.
If you require any further information please do not hesitate to contact me.
Looking forward to hearing from you regarding this matter.

Yours Sincerely

Code A

27/5/02 FORMAL COMPLAINT Cont: Concerning Stanley Carby 31/12/1933

Questions asked at meeting with Jan Peach an DR LORD.

1, Why was my Husband moved from a ward to his own room after i left him at around 5-30 pm on the 26th april 1999.

2, What time was it when my husband first became very unwell, with the need of concern.

3, Why was we not contacted sooner,

4, Who authursied drug's administerd, and what they were,

5. why did he die so shortly after leaving haslar.

Answers given by DR Lord & Jan peach.

1, At first she said we dont know the exact reason why he was moved, the only reason i can think of is that he needed to be observed more closely, because he was getting agitated.

2, they said early morning they couldn't say what time, but they did call DR, Lord.

3, When we said well why was we not contacted sooner, when Stan was first unwell they said he was ok untill 10-am when they phoned us, after looking at notes we noticed, it was early hours he was not well, So we questioned this and said, we should of been contacted then. All they said was we are sorry. we cannot explain why.

4, DR Lord was phoned and she suggested to give him midazalam, she then "DR lord" said they did not give MR Carby the midazalam, we asked her why!

Formal Complaint Cont:

She does not know why the reason they did not give him the Midazalam, after they phoned her to state that mr Carby was not eating or drinking.

5, Basicly they told us that my husband had everything against him, i told the doctor that Stan had alot of these things wrong for many years and i have looked after him. he was always stable minded and lived with the problems he had, She then went on Stating alot of medical terms.

I have applied for my husbands full medical notes. from haslar, I also have the notes Coming from haslar for the two week period he was in there before going to Gosport War memorial. if you would like to See a Copy as soon as i recieve them I can Send you them.

hope you Can deal with this Complaint at your earliest time, please feel free to Contact me if you need any more information.

yours faithfully

Code A

On this form is the list of drugs he was on at haslar, this was sent to war memorial with him, although his notes state, nothing was sent.

Ward A5
Royal Hospital Haslar
Gosport
Hampshire
PO12 2AA

26 April 1999

sport. Code A

Dear Colleague,

Thank you for accepting for rehabilitation this 65-year-old gentlemen. He was admitted on the 13th of this month with slurred speech, confusion and had been showing some aggressive behaviour. His past medical history includes hypertension, non-insulin dependent diabetes, prostatic hypertrophy depression and angina. He is also rather overweight.

As he is coming to you for rehabilitation, I am sure you will make your own assessment of his needs, I will therefore include just points of nursing note below.

Maintaining a safe environment

Stan requires help in maintaining all aspects of his safe environment. He attempts to walk and has fallen in his bids for independence on more than one occasion, thankfully without sustaining apparent injury. He has no known allergies.

Communicating

Stan has slurred but understandable speech, which has improved only slightly since admission. He shouts out, especially at night and at times becomes confused. He has no obvious sensory deficit.

Breathing

Stan is occasionally breathless on agitation. Before admission had panic attacks when he was anxious.

Eating and drinking

Stan is a tablet controlled non-insulin dependent diabetic. On admission he blood glucose level was 17.3 mmol/l. This has since come under better control and is in the range 5 – 8 mmol/l. He can take food and fluid with little assistance but does not take enough fluid without regular encouragement. Stan's diet is far from ideal, he eats mainly puddings and chocolate!

Ward A5
Royal Hospital Haslar
Gosport
Hampshire
PO12 2AA

Daedalus Ward
Gosport War Memorial Hospital
Gosport
Hampshire

26 April 1999

Mr Stanley CARBY Code A

Dear Colleague,

Thank you for accepting for rehabilitation this 65-year-old gentlemen. He was admitted on the 13th of this month with slurred speech, confusion and had been showing some aggressive behaviour. His past medical history includes hypertension, non-insulin dependent diabetes, prostatic hypertrophy depression and angina. He is also rather overweight.

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Personal cleansing and dressing

Stan showered daily prior to admission. Unfortunately, our facilities do not allow a man of Stan's physique to take a shower and he has had his hygiene needs met with bed baths or baths using a hoist and sling.

Controlling body temperature

Stan controls his temperature independently, removing layers of clothing or bedding as required. He has been apyrexial for the majority of his admission but normally lies in bed without covers or clothes.

Mobilising

Prior to admission, it is reported that Stan would walk around his house independently. Since admission, he has walked only occasionally and then very unsafely and has indeed fallen. The majority of his movement has been by hoist and he does not find using a hoist and sling uncomfortable.

Working and playing

Stan has done very little in the way of interacting with other patients. He did not go out before admission and lists his only interest as television.

Expressing sexuality

Stan is overtly heterosexual in his speech and manner. He is married and has five children.

Sleeping

Stan is a very poor sleeper, managing only two hours at night, but dozes throughout the day. He has a tendency to try and wander more at night, as was his norm at home.

Elimination

Bowel – Stan is incontinent of faeces. He has his bowels open daily, as was his pattern at home.

Urine – Stan has a urinary catheter in place, through which he is passing urine with some blood due to trauma caused by his pulling it. He is requiring bladder washouts regularly and the catheter was changed today.

Current medication

Stan's current medication is:

Metformin	500mg orally	TDS
Glibenclamide	5mg orally	TDS
Enalapril	20mg orally	BD

Finasteride	5mg orally	OD
Frusemide	80mg orally	OD
Amitriptyline	25mg orally	OD at night
Aspirin	300mg orally	OD
Simvastatin	20mg orally	OD at night
Elocon cream	topically to skin lesion	OD
Canesten cream	topically to required areas	BD
Bactroban	Topically to abdomen	OD

He also uses GTN on an as required basis and Temazepam 20mg orally at night as required.

Next of kin

Mrs Carby (Stans wife)

Code A

I hope the above information is of use, if further information is required, please do not hesitate to contact this ward on Code A

Code A

DP Wilcock
Registered Nurse (Adult)

Please note that this is where we stated that please could they contact us any time, day or night if any change, we were prepared to come in and help if my husband was agitated.

*

General Information

ey	Date of Birth 65y
TAN	Day Code A / Month Code A / Year Code A
...ers Lane	Religion C of E
	Ethnic Origin
...ost code	**Allergies**

Next of Kin	Carer/Contact/Confidante
Surname Mrs Cardy	Surname Mrs McKay
Forenames	Forenames
Address S/A	Address
Post code	Post code
Relationship Wife	Relationship Daughter
Tel Nos: Home Code A	Tel Nos: Home Code A
Work	Work

* Contact any time if condition changes *

Useful Information

Hospital Information	Community Information
Hospital: GWMH Tel No: Code A	District Nurse: Tel No:
Hospital No:	G.P.: Dr. D. Young Lowner H.C. Tel No:
Named nurse: Janet Neville	Bank Holiday Tel No:
Ward: Daedalus Tel No: Code A	Weekends: Tel No:
Consultant: Dr Lord	Twilight Nurse: Tel No:
Manager: Philip Beed Tel No: Code A	Manager: Tel No:

Patient code

△ Code					

NR1

G100396 [illegible]
CARBY STANLEY
[illegible]
[illegible]
[illegible]
HANTS [illegible]
[illegible].12.19[illegible] [illegible]
DR DA YOUNG

General Information

Surname: CARBY
Forenames: STANLEY
Likes to be known as: STAN
Address: Code A
Code A
Tel No: ...... Post code: ......

Date of Birth: 65y
Day: Code A Month: Code A Year: Code A
Religion: C of E
Ethnic Origin: ......
Allergies ......

Next of Kin	Carer/Contact/Confidante
Surname: Mrs Carby	Surname: Mrs McKay
Forenames:	Forenames:
Address: S/A	Address:
Post code:	Post code:
Relationship: Wife	Relationship: Daughter
Tel Nos: Home: Code A	Tel Nos: Home: Code A
Work:	Work:

* Contact any time if condition changes *

Useful Information

Hospital Information	Community Information
Hospital: GWMH Tel No: Code A	District Nurse: Tel No:
Hospital No:	G.P.: Dr. D. Young Lower H.C. Tel No:
Named nurse: Janet Neville	Bank Holiday Tel No:
Ward: Daedalus Tel No: Code A	Weekends: Tel No:
Consultant: Dr Lord	Twilight Nurse: Tel No:
Manager: Philip Beed Tel No: Code A	Manager: Tel No:

Patient code

△ Code

NR1

Code A

Code A

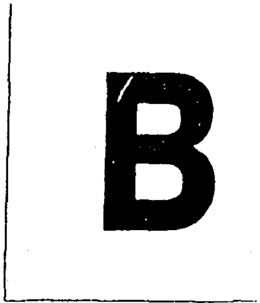
Code A

Code A

Code A

Code A

Code A



PRESCRIPTION SHEET

for the safety of the patient

DOCTOR

1. Use approved names, BLOCK LETTERS, and metric dosage.
2. Be specific in indicating the timing and route:-
   - (a) For regular prescriptions tick (✓) the appropriate boxes and indicate time in blank space.
   - (b) For drugs which are likely to have frequently changing doses, use the section at "Daily Review Prescripti on back of sheet.
3. Any CHANGES in your drug therapy MUST be ordered by a NEW PRESCRIPTION: do NOT alter exis instructions.
4. Discontinue a drug by clearly crossing out the discontinued drugs (viz TETRACYCLINE) draw line through unused recording panels and sign in with full name.
5. Prescribe INFUSION THERAPY and any drugs to be added on the INFUSION CHART.
6. Take home drugs will be written up on form MR15 which then will be placed in the appointment and prescript record card.
7. All prescriptions must be signed in full.
8. The following should be used to indicate route.

   S.C. .... Subcutaneous
   I.M. .... Intramuscular
   I.V. .... Intravenous
   Sub Ling .... Sublingual
   Intrathecal
   Oral
   Rectal
   Topical
   P.V. - per vaginum

9. Put date prescription needs to be reviewed in "review" box of Regular Prescription Section.

NURSE

1. Initial the administration in the appropriate box. (This must be done by the Senior Nurse).
2. Check all sections to avoid omission.
3. Use the top continuation sheet only for recording administration.
4. If a dose is missed write "X" in the box and give the reason in the Exceptions to Prescribed Orders.

If for some reason **all** the drugs prescribed for a certain time are not given, e.g. patient fasting, patient absent, th is no need to itemise each drug. Enter date, time and write **ALL** in name and dose column.

ADDITIONAL CHARTS		
	ANTICOAGULATION	
	INTRAVENOUS FLUIDS	
	INTRAVENOUS INFUSIONS	

Code A

Code A

Code A

GMC100942-0135

DAILY REVIEW PRESCRIPTIONS

REGULAR PRESCRIPTION		Date →											
		Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose
DRUG (Approved Name)													
Route	Pharmacist												
SIGNATURE													

		Date →											
		Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose
DRUG (Approved Name)													
Route	Pharmacist												
SIGNATURE													

		Date →											
		Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose
DRUG (Approved Name)													
Route	Pharmacist												
SIGNATURE													

		Date →											
		Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose
DRUG (Approved Name)													
Route	Pharmacist												
SIGNATURE													

		Date →											
		Time ↓	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose
DRUG (Approved Name)													
Route	Pharmacist												
SIGNATURE													

FOR NURSING USE ONLY – EXCEPTIONS TO PRESCRIBED ORDERS

Date	Time	Drug Name and Dose	Reason	SIGNATURE

As you can see nothing has been wrote down in this sheet. So what is the reason for them to be crossed out. ?

This is Care plan !
Re[illegible]ires assistance to Settle and sleep.
—
Nothing done.

NIGHT CA[illegible]

Daedalus Ward GWMH
Nursing Care Plan

Stanley Carby

S.N. J. Neville

nce to settle and sleep at night

	Desired Outcome:
	*Patient to be able to settle into bed, at a time suitable to them, and engaging any pre-sleep routine they are comfortable with** *To sleep for as long as he/she wishes, waking in his own time & feeling refreshed.* ** specify if applicable*
	Evaluation Interval or Date:
	Night & morning
	Nursing Action:
	Ensure comfortable & warm in bed *Night sedation if required (monitor effectiveness)* *Observe for pain* *Remove dentures* *Call bell at hand*
	Signature of Nurse Initiating Care Plan **Code A**
	Evaluation

NIGHT CA

Daedalus Ward GWMH
Nursing Care Plan

Patient: Stanley Carby

Named Nurse: S.N. J. Neville

Date	
	Problem:
26/4/99	*Requires assistance to settle and sleep at night*
	Desired Outcome:
	*Patient to be able to settle into bed, at a time suitable to them, and engaging any pre-sleep routine they are comfortable with** *To sleep for as long as he/she wishes, waking in his own time & feeling refreshed.* ** specify if applicable*
	Evaluation Interval or Date:
	Night & morning
	Nursing Action:
	Ensure comfortable & warm in bed *Night sedation if required (monitor effectiveness)* *Observe for pain* *Remove dentures* *Call bell at hand*
	Signature of Nurse Initiating Care Plan **Code A**
	Evaluation

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

I'm not surprised no urine in bag. he hadn't taken no fluid since leaving haslar the morning before

CATHET

Daedalus Ward GWMH
Nursing Care Plan

Stanley Carby

S.N. J. Neville

tinence
welling urinary catheter, and is at risk from infection, trauma, &

Desired Outcome:

Maintenance of catheter patency
Prevention of urinary tract infection

Evaluation Interval or Date:

Daily

Nursing Action:

Promote & monitor fluid intake
Monitor urine output for blockage & infection
Maintain catheter hygiene
Change catheter bag weekly
Secure catheter bag with leg straps

Signature of Nurse Initiating Care Plan Code A

Evaluation

Code A

Code A

Code A

GMC100942-0150

I hope to get him a[illegible] to [illegible] War Memorial, though theoretically he is under a[illegible] I will try and [illegible] this [illegible] out.

Thank you for asking us to [illegible] hi[illegible]

Yours sincerely

Dr J C Tandy
Consultant Physician in Geriatrics

Dr D Young
Rowner Health Centre
[illegible]43 Rowner Lane
Gosport

P[illegible]: As I was leaving his wife told me that he sleeps very badly at [illegible] and is somnolent by day. I suspect he is a likely candidate [illegible] sleep apnoea syndrome, but pursuing this avenue would not be helpful at present.

21-APR-1999 09:39 ELDERLY MEDICINE 01705 200381 P.01

Portsmouth
HealthCare
NHS
TRUST

DR J C TANDY
CONSULTANT GERIATRICIAN

Elderly Medicine
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY

Tel: 01705 822444
Extension:
Direct Line: Code A
Fax: 01705 200381

JCT/CMT/WV

20th April 1999

Surgeon Captain Edmondstone
c/o A5 Ward
RH Haslar
Gosport

Dear Surgeon Captain Edmondstone

Ward Visit
Stanley CARBY dob Code A
In-Patient A5 Ward RH Haslar
H/A: 52 Brookers Lane, Gosport

Diagnosis : 1. Left hemiplegia secondary to CVA
2. Obese
3. Hypertension
4. Cardiac failure
5. NIDDM

Thank you for asking me to see this 65 year old gentleman who was admitted six days ago with a left hemiplegia. CT showed a right parietal infarct and old lacunar infarct.

Normally he lives with his wife. They have a toilet downstairs. He had been more or less housebound for sometime.

He is now eating and drinking with assistance, though he is pocketing his food. His speech is still slurred. He has required a hoist to transfer. He has a catheter in situ though his bowels are continent.

He is very obese at 21 stones. He looks cyanosed though his sats were 94-95%. He was in sinus rhythm with a blood pressure of 130/75. He has a left homonymous hemianopsia and left upper motor neurone 7th with slurred speech. He had a flicker of movement in his left hand and in his toes, though no movement in the hips, elbows or shoulders. He also had diminished sensation on the left.

In summary this chap has a left hemiparesis. His weight and density of stroke will make mobilisation more difficult.

/continued..

Telefax
To: Daedalus Ward
Fax: 811376
From: C Elderly Medicine
Date: 21-4-99 Pages: 2

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

In reply please quote **MH/FPD/2002/1345**

7 June 2002

Mrs R Carby

Code A

Dear Mrs Carby

Thank you for your letter dated 27 May 2002. Your correspondence is being considered and we shall write again as soon as possible.

Your case has been allocated the following reference number **MH/FPD/2002/1345.** It would be very helpful if you could quote this reference number whenever you write or speak to us.

If you have any questions please contact myself or the officer in charge of this case, who is **Mr Michael Hudspith, tel.** **Code A**

Yours Sincerely

Code A

Thomas Wood
Fitness to Practise Directorate
Tel: 020 7344 4746
Fax: 020 7915 3642
Email: **Code A**

Your ref:

Our ref: 2002/1345

05 August 2002

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

First Class Post

Mrs R Carby

Code A

Dear Mrs Carby

Dr Jane Barton (1587920)

I write further to your letter of 27 May 2002 concerning Dr Barton and other. Please accept my apologies for the very lengthy delay in responding.

I have enclosed a leaflet which explains the GMC's remit and how we assess complaints and I hope you find this information helpful. It is important that you read it so that you understand from the outset what we can, and cannot, do. Our role is to license doctors to practise in the United Kingdom. Although we provide guidance to doctors about what constitutes good medical practice, not all alleged breaches of that guidance will warrant formal action by us. We have power to take action against a doctor *only* where their behaviour justifies our restricting or removing their permission to practise medicine. In legal terms this behaviour is described as 'serious professional misconduct' or 'seriously deficient performance'. In short, we are able to use our powers where we consider a doctor to be a threat to patients' health or well-being.

Please note that our jurisdiction only covers doctors and we are therefore unable to consider any complaints about nursing staff. The professional body which regulates nursing and midwifery is the Nursing and Midwifery Council (NMC) 23 Portland Place London W1B 1PZ.

I should explain that no decision has yet been made about whether we can take action on the matters which you have raised. To help us decide whether we can assist, please complete the attached consent form and return it to us by 29 August 2002. If you answer no to any of the questions on the form it is unlikely that we can take this matter forward.

Upon receipt of the completed form, we will give further consideration to the matters you have raised. Your enquiry has been allocated the reference number FPD 2002/1345. It would be very helpful if you could quote this reference when you write or speak to us.

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
Direct Line: Code A
Direct Fax: Code A
e-mail: Code A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

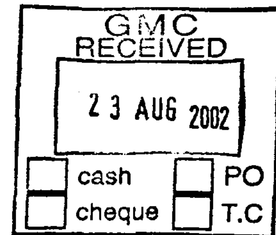
1H

GMC Case Reference Number: 2002/1345

Name of correspondent: Mrs R E Carby

- Are you willing to identify the doctor? YES ☑ NO ☐
- Are you willing to allow us to disclose your letter to the doctor? YES ☑ NO ☐
- If necessary, would you be willing to be a witness at a public inquiry? YES ☑ NO ☐
- Are you willing, in principle, to provide a Statutory Declaration in support of your case? YES ☑ NO ☐

NB **A Statutory Declaration is not necessary at this stage, but would be required later if there are grounds for action under our fitness to practise procedures**



Name of doctor(s)

DR BARTON
DR LORD

Declaration

I have provided the GMC with details of the doctor(s) about whom I have written and confirm that the GMC may disclose to the doctor(s) my letter, including any supporting documents, and any further information I may send to the GMC in connection with this matter.

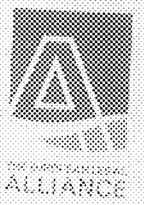
I understand that if I have answered no to any of the questions above, it is unlikely that the GMC will be able to take the matter forward.

Name (please print)......MRS R E CARBY.......................

Signature.... Code A ...... **Date**...19-8-02.....

E:\IIS\Letters\le

FIELD FISHER WATERHOUSE



NOTES

(1) Update
- GMC
- Police

(2) Disclosure

(3)

(1) Dr Barton → write to Dr Barton
→ draft for comment

(2) GMC to check complaints – provide letter
(3) NB missing records with GMC → we don't have any.

(4) Specialist help required → nothing → not required – identifiable

(5) Letter to Hampshire Constabulary –
→ formal disclosure

(6) GMC witnesses write Hampshire
GMC

W> BARTON
21/01/03

DI Nigel Niven
DC Chris Yates

1988 - 89 ... Barton started
↳ expanded ...

JZC ; Names of nurses ...

will send docs on file ...

Wolfied - neutral

; entirely reasonable
; no live witnesses

cc - to NN

Jane Barton
↳ widely flagged
- no effort to conceal
~ number of deaths
leeching to exp. connected crime and if so by whom
- has to be aware - no knows.
... only right and proper to notify her ...

Emphasise : police investigation and not accusing
- abuse of process.
+ police are doing something

Disclosure : JLC to ask for formal request ...

[illegible] → problems re 10C.

Code A

Qu:
MK : has she gone on palliative care course?

Code A

NN

later, support
GMC - discrete but findings rebut
- epidemiology ↓

[illegible] deaths - families forward
- expressed concerns
↓
fully review medical notes

Experts : headed up by Prof Robert Forrest
- palliative → GP
- Geriatric → [illegible]

Meet in next few weeks
Results : CD ? work distantly

10 ? experts for panel
... check out ...

3-6 months completion

→ interviews

Timetable → × 2-3 years
'due and diligent'

Clear idea where going by end of this year
Investigate
→ legal advice
... move quickly poss

[illegible] → in hands of experts.

Alexander Harris — will continue (good ...)
... robust with media (non involvement
... chairs same need ...

Code A

05/02 : Meeting with family group
AM + all other [illegible]
... open forum ...

GMC: fully involved circumstances
in liaising on regular basis.

ICC - entirely happy...

Q MK: GMC not have any ??

Experts:
1. causation
2. matters: mechanism medical, scientific basis

→ significant number of deaths
→ those cause concern and those that don't...

? exhumation ?
↳ unlikely to benefit.
↳ team confirm

→ Appropriateness of the treatment

Fresh evidence re any doctor
↳ obligation
↳ disclosure issues

Key issues: Risk; public interest

BARTON

PPC – 29-30 August 2002.

Drugs – diamorphine
– hyoscine
– midazolam
– haloperidol
– oromorph

– lack of psychogeriatric advice
– alternative treatment options / milder drugs × considered
– reasons not adequately recorded
– excessive, potentially hazardous amounts
– undated prescriptions

(1) Lord ✓
(2) Police ✓
(3) Further cases ✓
(4) 1991 allegations ✓
(5) Timescale

To Do:

(1) Obtain relevant extracts from
  (a) BNF
  (b) Product summary
  (c) ABPI Compendium

(2) Seek instructions about Dr Lord
  - would we wish to consolidate?

(3) Note adding of charge re 'happy'

(4) Referral of other professionals - query co-operation

(5) Contact N of K for consent to release of medical notes
  ★ obtain originals ★

(6) Police file

(7) Instruct expert — Consultant in palliative care & a teacher —
  - Prof GA Ford?
  - pharmacologist?

(8) Statements
  Query self-incrimination?

(Another unhappy relative - Ann Reeves -- p105)

~~(9) Experts~~ ★
~~(9) Police file~~ ---

Patient - Eva Page (1)

NoK = Bernard Page ~~Gillian Mackenzie & Lesley Lack (daughters)~~

Hospital Records - Queen Alexander Hospital
Dryad → - Gosport War Memorial
- GP

Admission 27/02/98 (carcinoma)
Treatment 03/03/98
→ died 03/03/98

Seen 28/02 - Dr Laing (duty GP)

Expert = Dr K I Mundy
18/10/01
→ no psychogeriatric advice taken
→ started on opiod analgesia inappropriately
→ subcutaneous diamorphine infusion had 10 fold range (20mg - 200mg)

Patient = Alice Wilkie (2)

N of K = Daughter, Mrs M Jackson

Notes = Queen Alexander
Daedalus → Gosport War Memorial

Admit - 06/08/98 - UTI
20/08/98

On admission seen by Dr Peters

Expert - Dr K I Mundy
~~18/10/98~~ 18/10/01

- no clear indication for opiod analgesic
- × simple analgesics given
- × documented attempt to establish nature of pain
- initial dose excessive
- 10 fold range for diamorphine

Patient = Gladys Richards (3)

N of K = Gillian McKenzie & Lesley Lack (daughters)

Notes - GP
- Haslar Hospital, Southampton
Daedalus - Gosport War Memorial Hospital
- Glen Heathers Nursing Home

Admit = 11/08/98 + 17/08 (Hip replacement - 28/07)
Drugs = 18/08 + 19/08/98
"happy for nursing staff to confirm death"

No foods 18 - 21/08/98

Died 21/08/98

Criminal investigation *

05/08/98 - seen by Dr Reid, consultant geriatrician
@ Haslar Hospital

Expert - Prof Brian Livesley
Report dated 10/07/01 →

first admission:
→ no clear reason for oramorph
→ drugs subcutaneously for undetermined number of days and wide range of doses

Witness - Lesley Lack
- Gillian Mackenzie
- Dr Reid

Patient = Arthur Cunningham (4)

N of K — Stepson, C/W Farthing

Admission for depression 07-08/98

Notes — GP

Dryad — Gosport War Memorial Hospital

Admit — 21/09/98 (sacral necrotic ulcer - L. ankle)

Drugs — 23/09/98 ↓

increased until death : 26/09/98

"happy" 4 nurses to confirm death

Expert = ~~Maw Harmondy~~ Mundy
18/10/01

↳ morphine started prematurely.
↳ x clear reason for syringe driver.
↳ dose increased w/o clear indication

Patient - Robert Wilson (5)

N of K - Wife

Notes - Queen Alexander Hospital
~~[illegible]~~ → Gosport War Memorial Hospital
+ Dryad - GP

Admit - 14/10/98 (fractured L humerous)
Drugs - 16/10/98

Reviewed by Dr Luznat, consultant psychogeriatrician
16/10/98 seen by Dr Knapman
18/10/98 seen by Dr Peters

Expert = Dr K I Mundy
"I consider that the palliative care given was appropriate"

diamorphine use: x comply with standard practice

	PAGE	WILKIE	RICHARDS	CUNNINGHAM	WILSON
Gillian McKenzie			✓		
Lesley Lack			✓		
Philip Beed (clinical manager/ Daedalus)			✓		
Margaret Couchman (SKN)			✓		
Christine Joyce (SKN)			✓		
Dr Althea Lord }	✓	✓	✓	✓	✓
Dr Jane Tandy			✓		
Dr Reid (on maternity leave)			✓		
Lesley Humphries ?			✓		
Jenny Brewer			✓		
Monica Pulford			✓		

16?

GMC100942-0169

	[illegible]	[illegible]	[illegible]	CUNNINGHAM	WILSON
Dr Peters		✓			✓
Dr ~~Wilson~~ Luznat					✓
Dr Knapman					✓
Mr Farthing (stepson)				✓	
SN Tubbritt				✓	
~~Daughter~~ Greg Bernard Page		✓			
SN Sylvia Roberts		✓			
Dr Page Laing	✓				
Mrs Jackson (daughter)		✓			
Iain Wilson (son)					✓

GMC100942-0170

GMC100942-0171

BARTON
20/11/02

Michael Keegan — Owen Kenny
Mr JLC — Nigel Niven
JHD

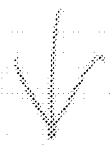
Alexander & Co

[illegible] . [illegible] cannot [illegible] proceed to public

Wed 8th January 2002

Copies to Niven
@ 11(2).

1997 - 98 — concerns by relatives



investigation [illegible] not effective

Continuing investigation...

CPS — relatives — [illegible]
With a view that causation not made out
(not come up to proof ...)

Families not well rec'd
& other cases — [illegible]

Causation established ??
James: not [illegible] at that [illegible]

Families: too quick to conclude the matter

DI [illegible] — prepared file again for CPS
when CPS based on 5 cases.

Still have to fully investigate a number of other cases

Causation: [illegible]
On [illegible] / similar fact basis

Cause concerns — appropriateness of regime "syringe"
~ indications for

But for cause of causation resulted in death...

Inappropriateness to amount to bad-practice

x Expert →
↳ expression of honor c systematic [illegible] evaluation
↳

↳ even on that limited number cases?

3) cases ~

Sharing of cases
Increasing of the view that counsellor entitled to challenge.

Stick with names brought forward,
or look at 100s died ?

useful Dr Barton or
in result of care

May not have been reported with hospital

Theme: Jane Barton
↳ reliance on diamorphine
+ syringe driving

Looking —
.. not reasonable to rely on causation

? motive? — continuing to look...

Decisions in other peoples behalf...

1994 – 1000s
600 – certified by Dr B

JO : policy decisions,
... stick or go pro-active

NW:
Test of case > similar fact
↳ comes a stage when statistically can support a case...

Team : 11 people

2 – Holmes
2 – indexers

4 – DCO

Decision – Dian Baber
↓
showed – retrospectively pattern
change in diamorphine
+ fatalities

? private practice

Prof Baker - will take a long time

* "a cultural incident"

1991

Phase 1 →
Phase 2 → Prof Robert Forrest

Timescale 1-2 years

(a) Causation
(b) Experts

(1) Close → CPS → 28/11
Capitulation

Write in lines of vein — ask to stop investigations

Steve Watts – Head Hampshire CID → back

As soon as idea CPS : acknowledged total closure
pending procedures —
stay of proceedings —

→ email;
→ phone;
→ mail.

Quickly & properly
Commitment to liaise closely

(2) Seeing Dr Granville (Chipman)

IOC (Jumble;)

→ what did Baron

- Once we finish have all

- Letter re investigation
  min 50
  early external advice may be

will be able write ... organise
 (what they have
 numbers involved
 export
 (private practice)

Able to go down to OCC...

[illegible] level of history of qualifications
 Can we pass little to etc!

Other doctors involved —
 A reluctance of too quickly resorting to care — but
 may be problems with other doctors ...

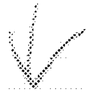
Can't be seen to persecute Jane Barton

JLC to 'phone monthly

Significant event → will tell if inappropriate

Assumption of innocence
unless letter ...

Anne Alexander :



Lawyers are liaising

Meeting : formal channels of communication
– happy for family to raise concerns through
her own firm

Not refer new people –
will keep talking
& non-adversarial

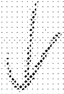
Concerns – w/o people like her the various stakeholders
don't talk

Updates : GMC are communicating
Different roles ...

GMC100942-0179

V. professional basis.

Draft Disclosure



will base when we have ...

Michael Keegan
Peter Swain
MSL
JLC

Issues

1998

V. powerful case on her self
MSL → resource issue
→ will be difficult to attack

Anyway to read – LOC ...

PS: Open minded

MSL: Locum ...
No normal person

But: 1991 ?
Long-standing concern re hastening death

Shaping changes ..

Lower case for PCC.

End of life - treatment

Expert: Consultant in District Hospital

Problems with practice but not Shipman-esque

PS: If go for a 'more realistic' case.
criticised in
↓
indirect pressure to get on — and CMO
pressuring for IOC

No agenda re particular result — show
fully explored ...

SL Chi report → will provide background info.
Want to see everything
Look at clinical setting: will be able to
support burden or otherwise

P: Memo of understanding

SL: Police?

K: Nothing much change.
Submitted to CPS
V. unofficially x proceed ...

Submitted: Richards — CPS only ...
Daughter + other families' released.
Different officer → sent to CPS.

MSL : Early meeting to with James —
Go thru whats going on —

↳ OKCC

— Statements from nurses
— Statements from family

↳ see what ford says — — cannot unilaterally take 'case' down fwd —

Happy

Other cases?

Hudsmith : further cases prompted by media coverage

after KB; OH PPC

— query receipt —
Not reasonable to postpone —

All new complaints sent to us to investigate and decide whether Rule 11(2) (if not stand up — back to screener
... for cancellation).

Td:
Screened and screened out.

JSG
Go and see file.

PS Get everything into 'our part of the world'

MSL : Nothing else to do on land
Qu about what we want to do —

PS : Explore as fully as possible
An expert report

1991 Allegations
MSL : Nothing
Seminal: new evidence and show long-standing Pt
Could regard as 'bigger papers' but
Opinion point but screened not add anything to weight.

IOC → Why not conditions?

Political ;

Local bods : Mike Gill ... feeling heat

MSL : Reneo when info from Mike Hudsmith

PS : No justification to go back → P Philips

Written advice on the point –
Headed HW –

Lincolnshire

Effect by CRS

Papers on understanding that do nothing with it
ready to roll out quickly

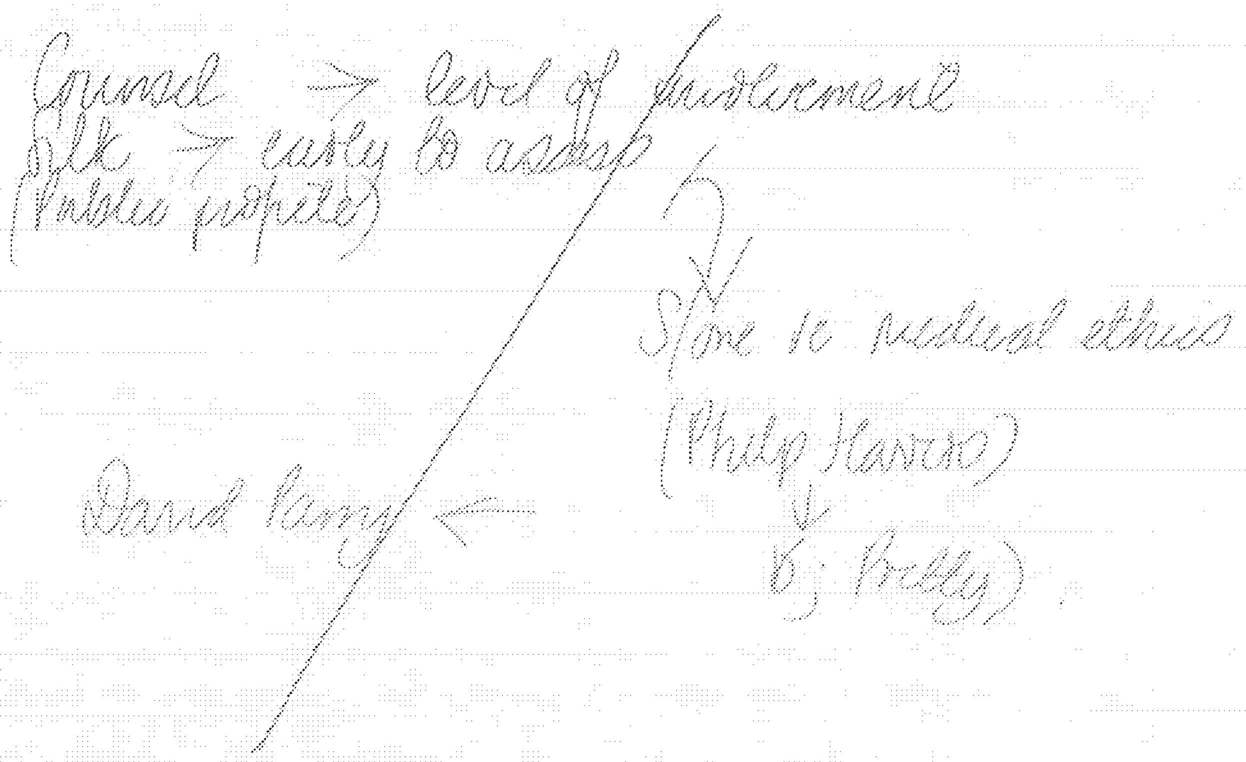
MSL : CRI report
Dialogue with expert in Newcastle see of
change recommendations –

Valley Simpson → happy with that –

Register of different factors in play
March

New complaints in effect –
CRS : not sat on decision

Medical remit :
Nofk



OKCC :
Can get police statements –

Difference : new evidence
– evidence exists already

MSL : Make enquiries with OKCC

Monthly meetings – outside of review –

① Police
② CH
③ PH Screening

investigation

Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital

JULY 2002

CHI
COMMISSION FOR HEALTH IMPROVEMENT

GMC100942-0187

Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

JULY 2002

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- 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

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)

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- 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.

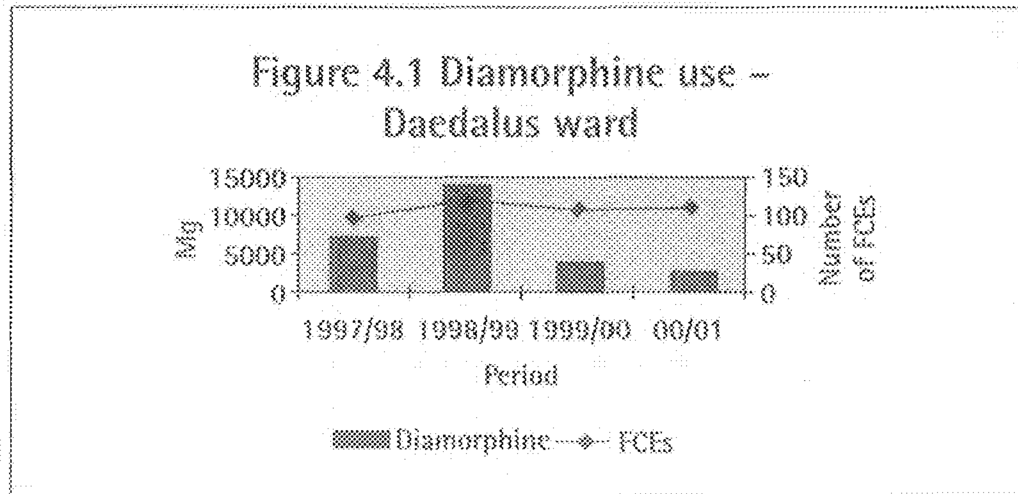
Medicine usage

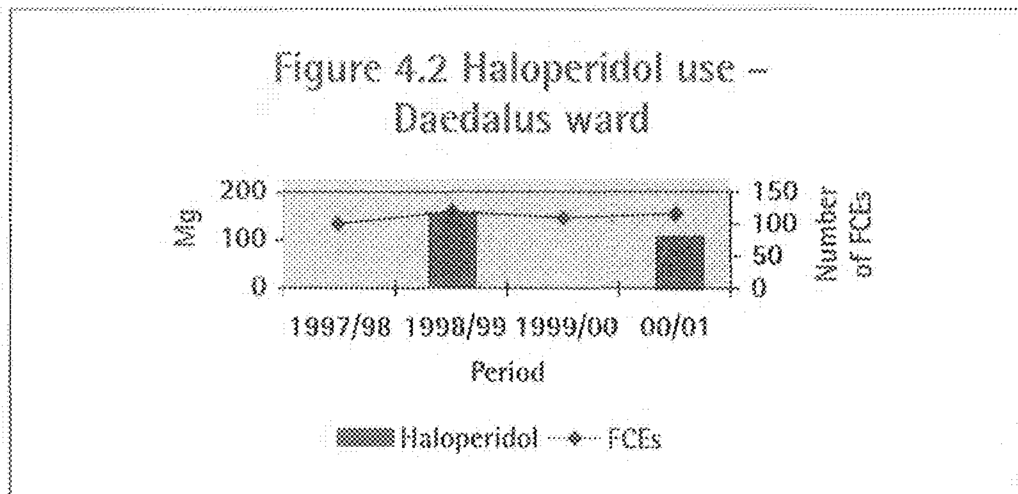
4.3 In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines 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.

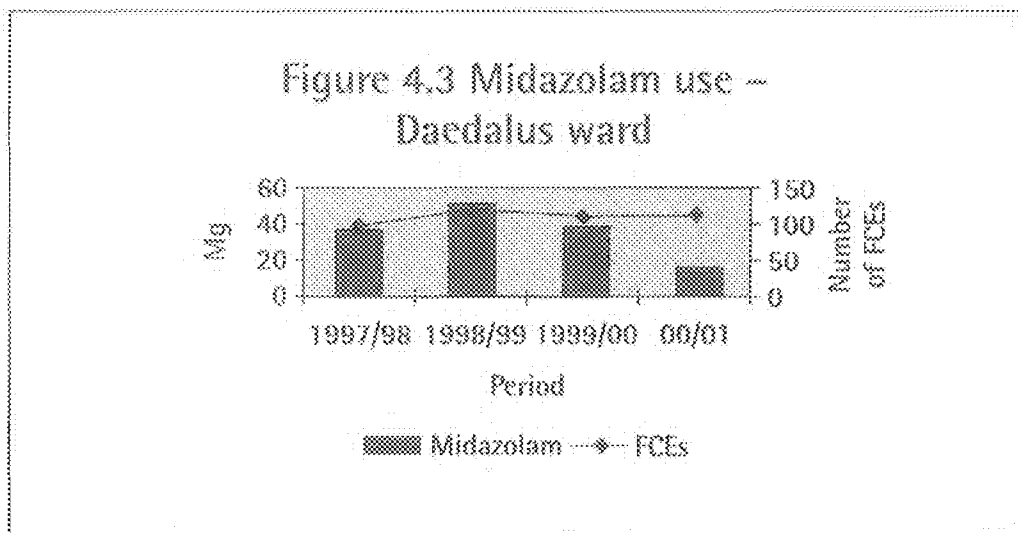
4.4 The experts commissioned by the police had serious concerns about the level of use of these three medicines (diamorphine, haloperidol and midazolam) and the apparent practice of anticipatory prescribing. CHI shares this view and believes the use and combination of medicines used in 1998 was excessive 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)







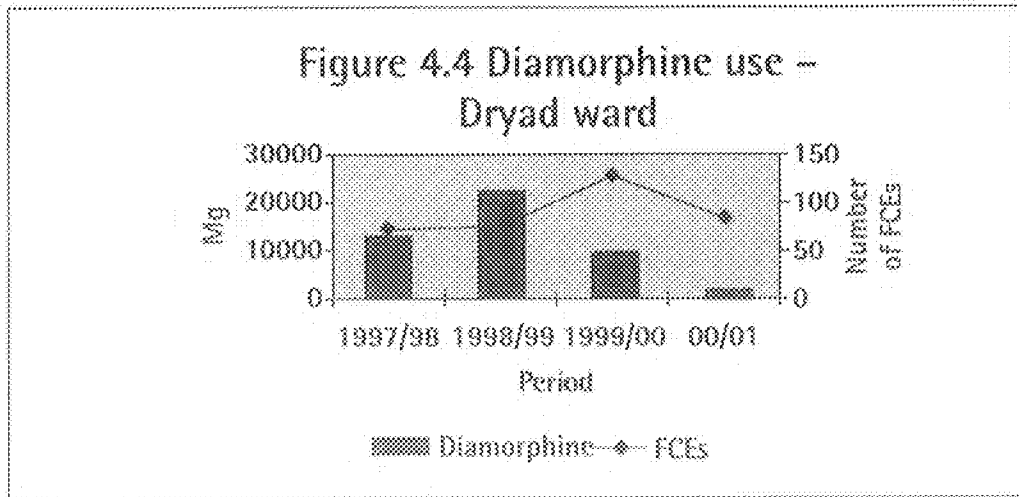


Figure 4.4 Diamorphine use – Dryad ward
30000
20000
10000
0
Mg
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Diamorphine
FCEs

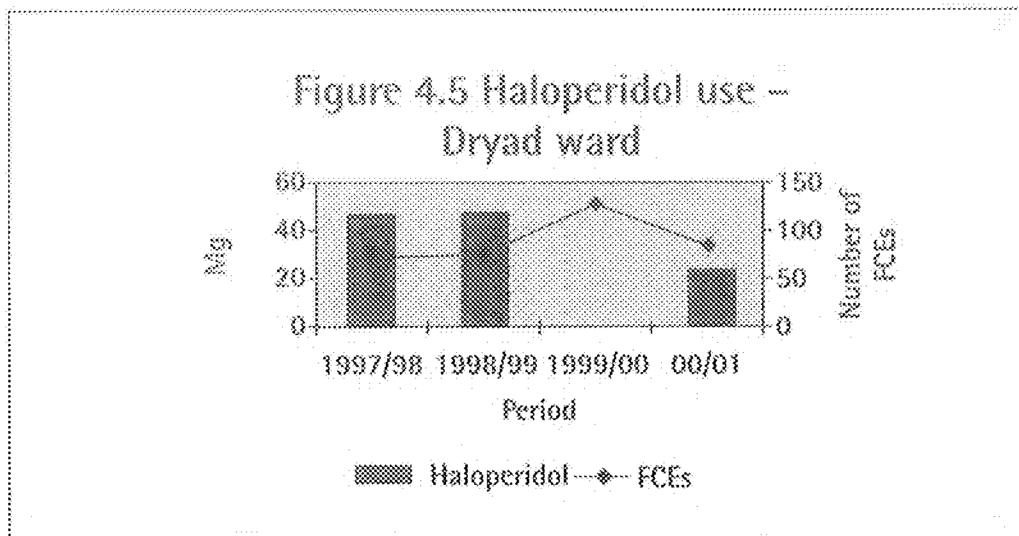


Figure 4.5 Haloperidol use – Dryad ward
60
40
20
0
Mg
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Haloperidol
FCEs

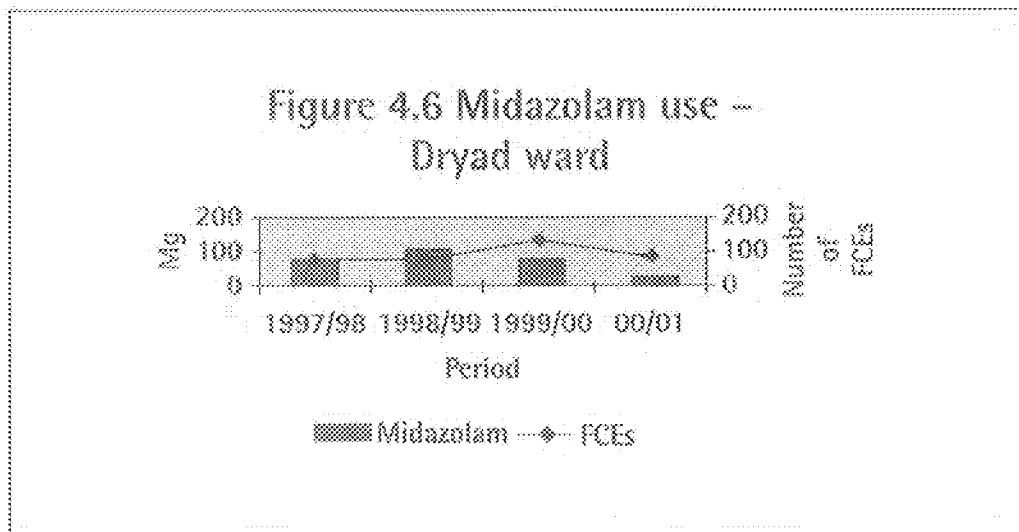


Figure 4.6 Midazolam use – Dryad ward
200
100
0
Mg
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Midazolam
FCEs

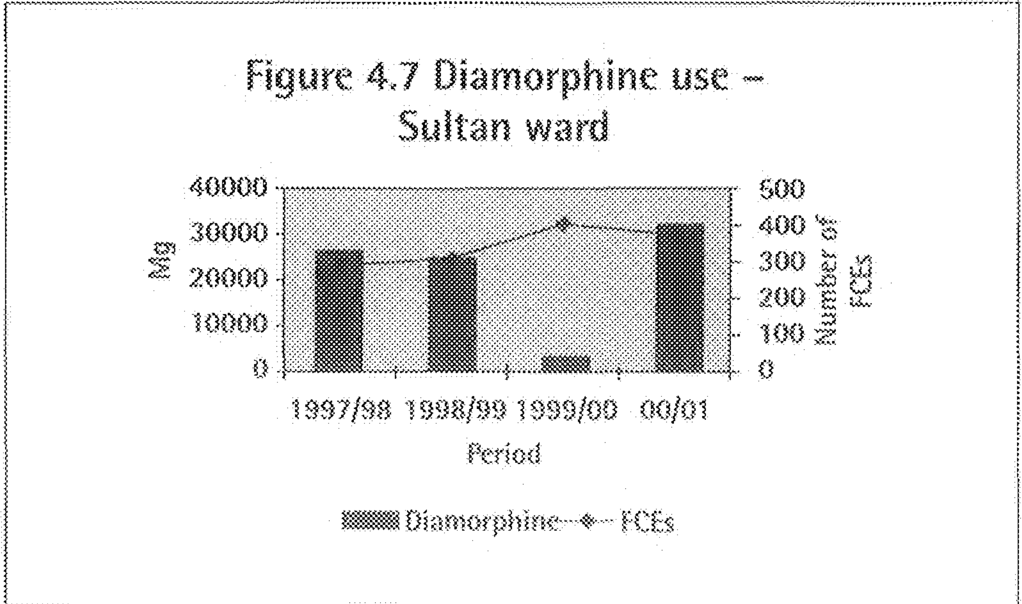


Figure 4.7 Diamorphine use – Sultan ward
Mg
40000
30000
20000
10000
0
500
400
300
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Diamorphine FCEs

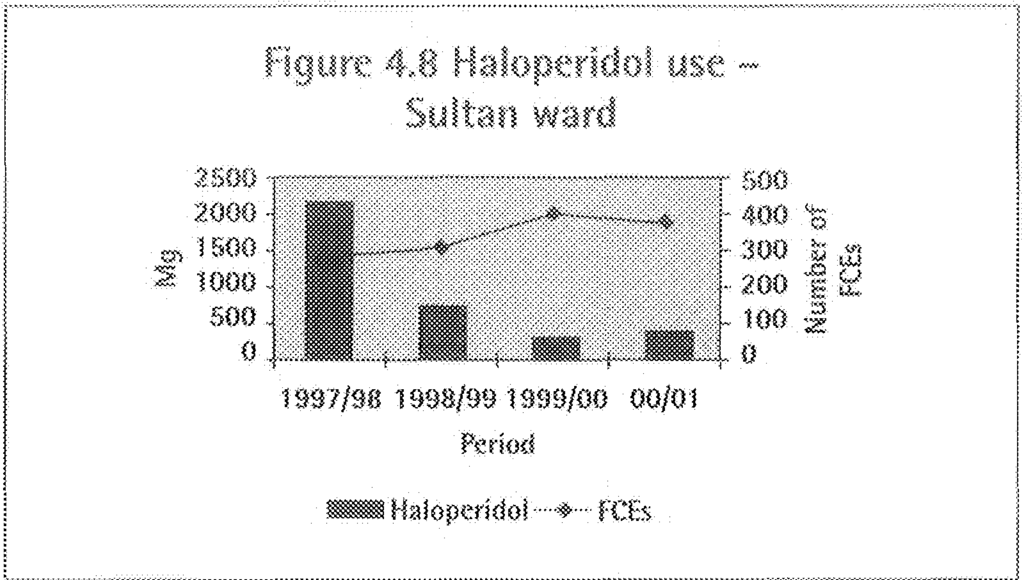


Figure 4.8 Haloperidol use – Sultan ward
Mg
2500
2000
1500
1000
500
0
500
400
300
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Haloperidol FCEs

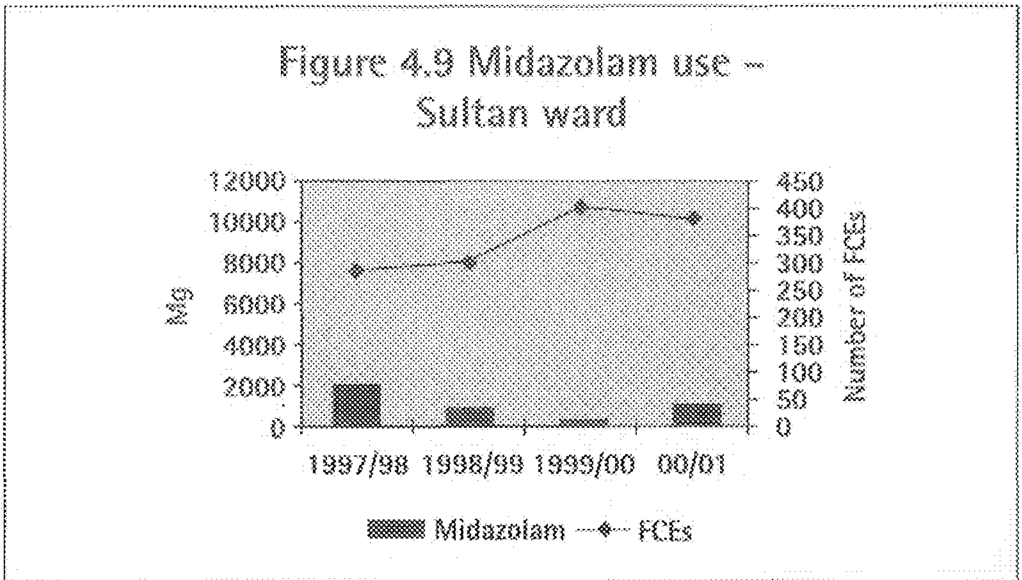


Figure 4.9 Midazolam use – Sultan ward
Mg
12000
10000
8000
6000
4000
2000
0
450
400
350
300
250
200
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Midazolam FCEs

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.

GMC100942-0225

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.

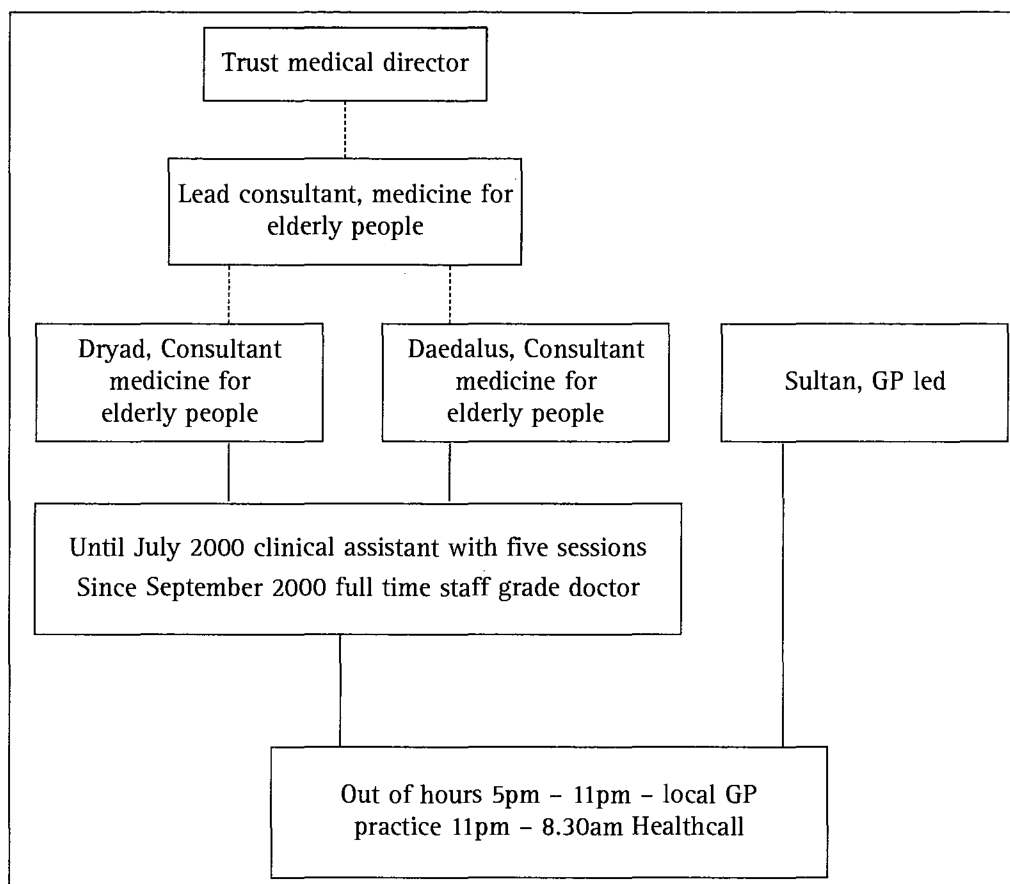
Medical responsibility

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.

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
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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

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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

- 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

- **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

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).

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.

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.

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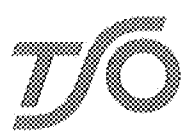
Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital - July 2002



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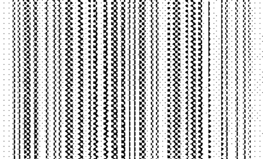
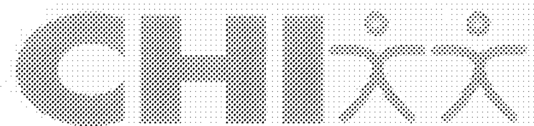


investigation

Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital

JULY 2002



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Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

JULY 2002

CHI
COMMISSION FOR HEALTH IMPROVEMENT

GMC100942-0278

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- 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

GMC100942-0283

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.

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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.

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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.

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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.

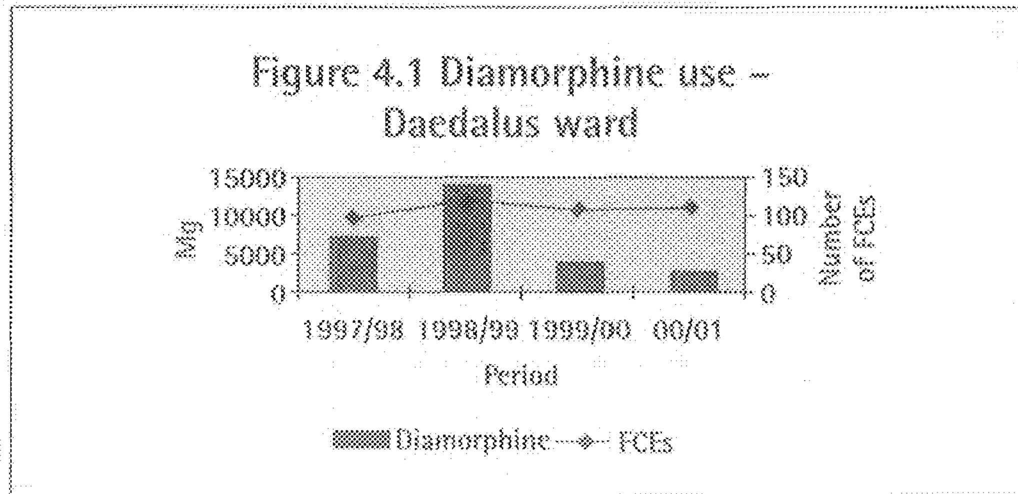
Medicine usage

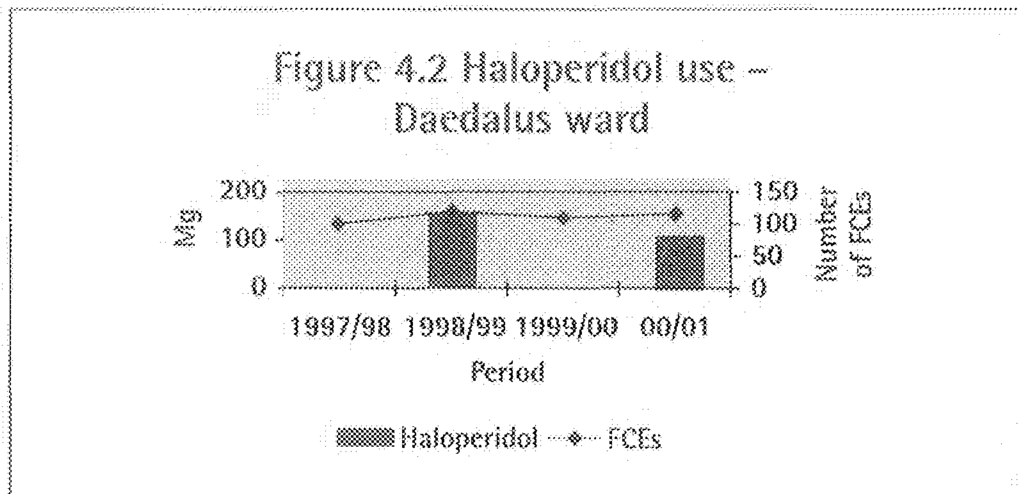
4.3 In order to determine the levels of prescribing at the trust between 1998 and 2001, CHI requested a breakdown from the trust of usage of diamorphine, haloperidol and midazolam for Daedalus, Dryad and Sultan wards. Data was also requested on the method of drug delivery. The data relates to medicines 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.

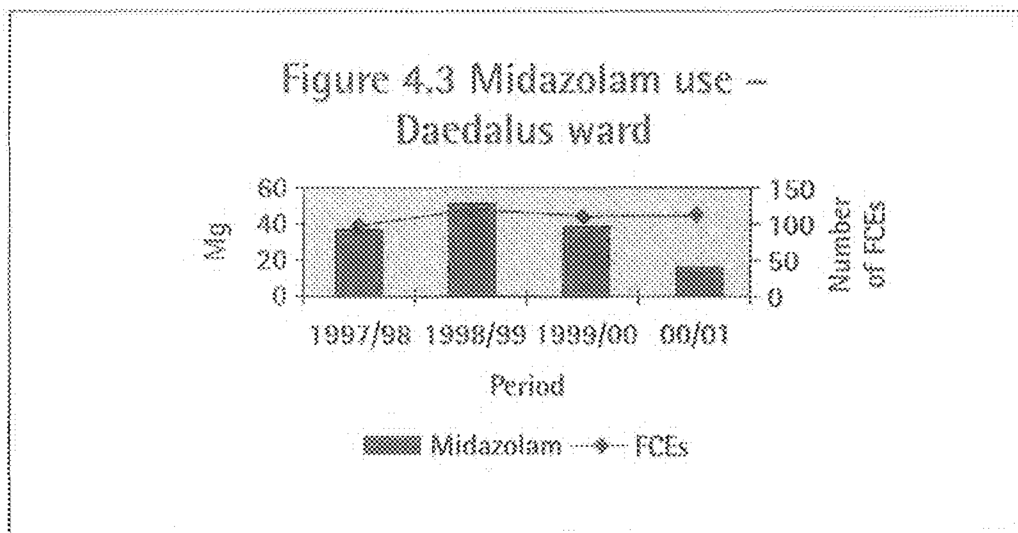
4.4 The experts commissioned by the police had serious concerns about the level of use of these three medicines (diamorphine, haloperidol and midazolam) and the apparent practice of anticipatory prescribing. CHI shares this view and believes the use and combination of medicines used in 1998 was excessive 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)







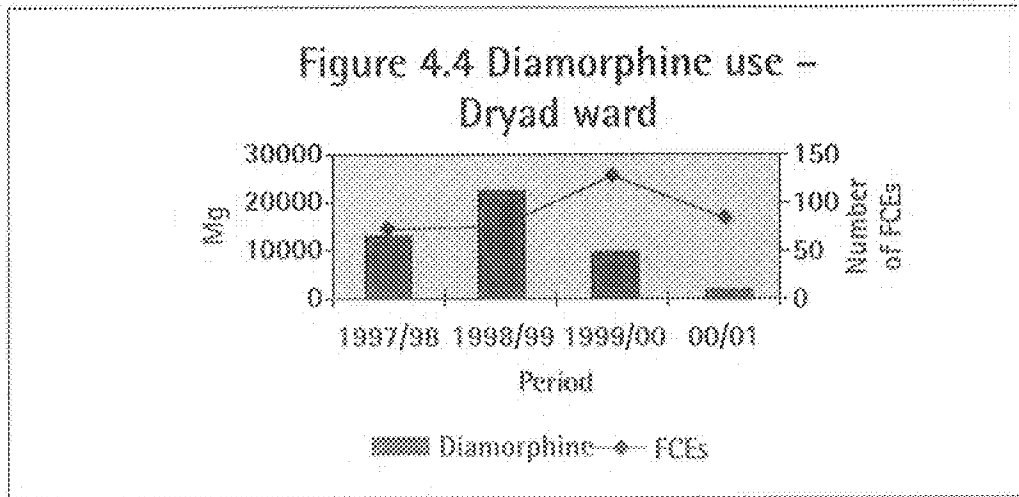


Figure 4.4 Diamorphine use – Dryad ward
30000
20000
10000
0
Mg
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Diamorphine
FCEs

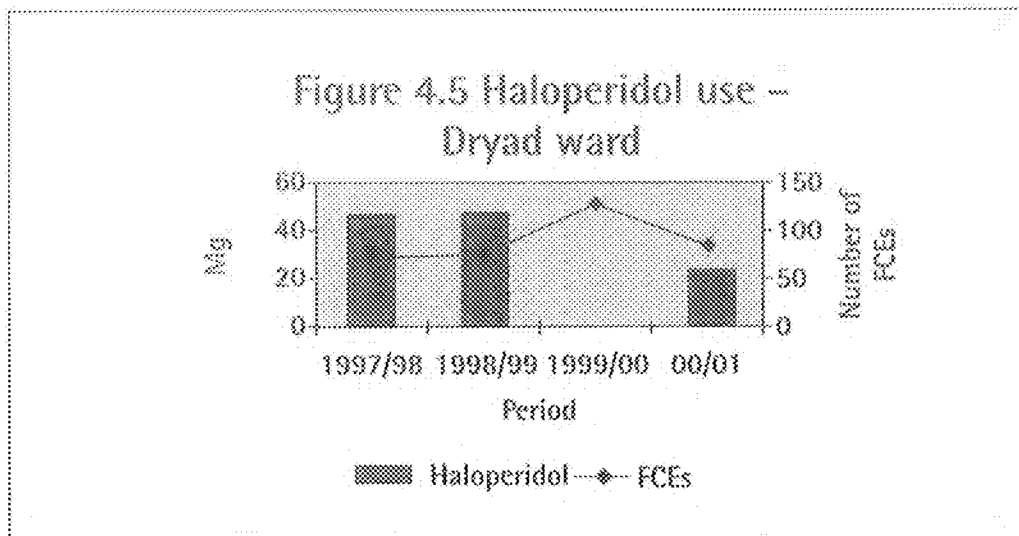


Figure 4.5 Haloperidol use – Dryad ward
60
40
20
0
Mg
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Haloperidol
FCEs

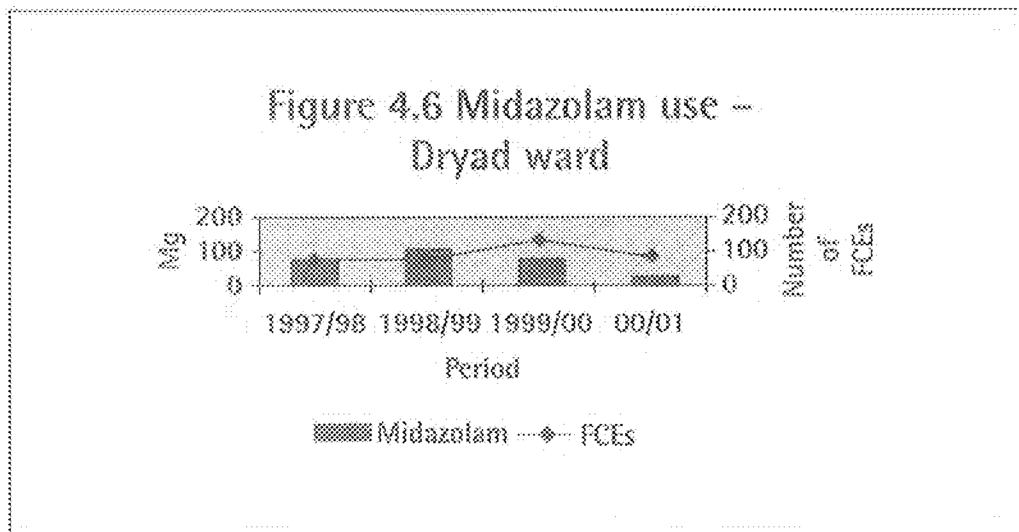


Figure 4.6 Midazolam use – Dryad ward
200
100
0
Mg
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Midazolam
FCEs

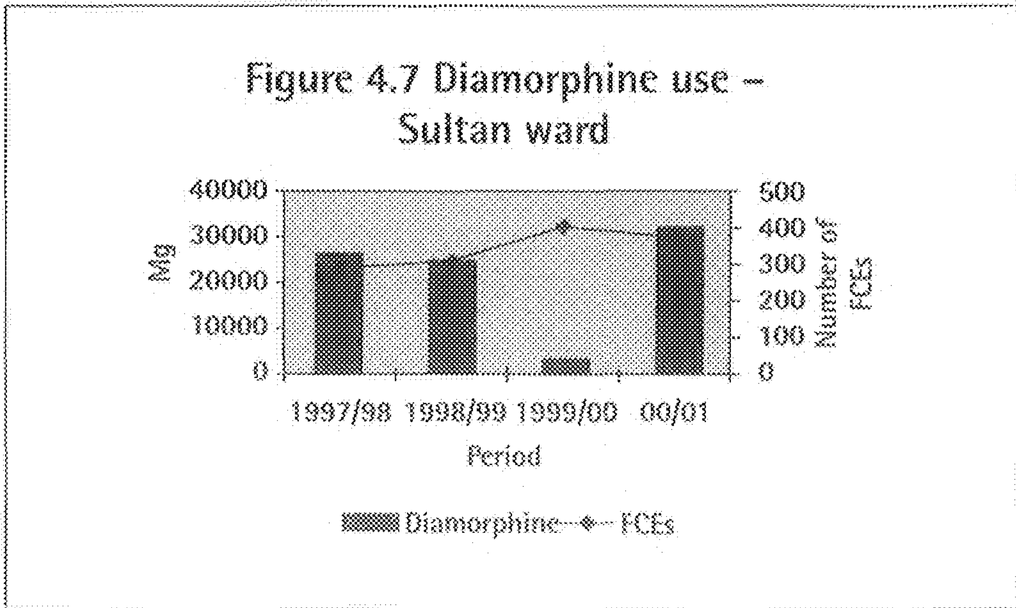


Figure 4.7 Diamorphine use – Sultan ward

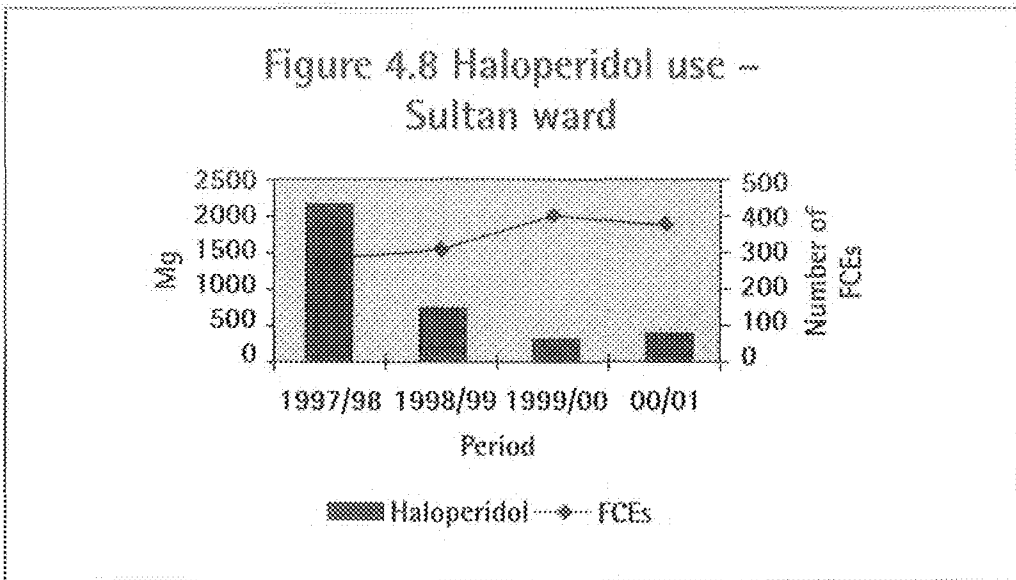


Figure 4.8 Haloperidol use – Sultan ward

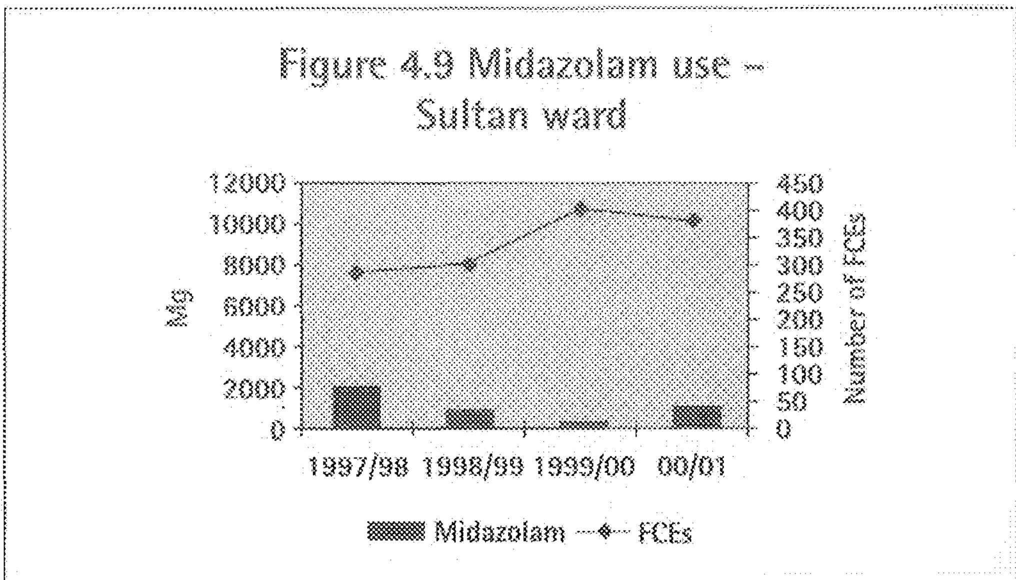


Figure 4.9 Midazolam use – Sultan ward

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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.

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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.

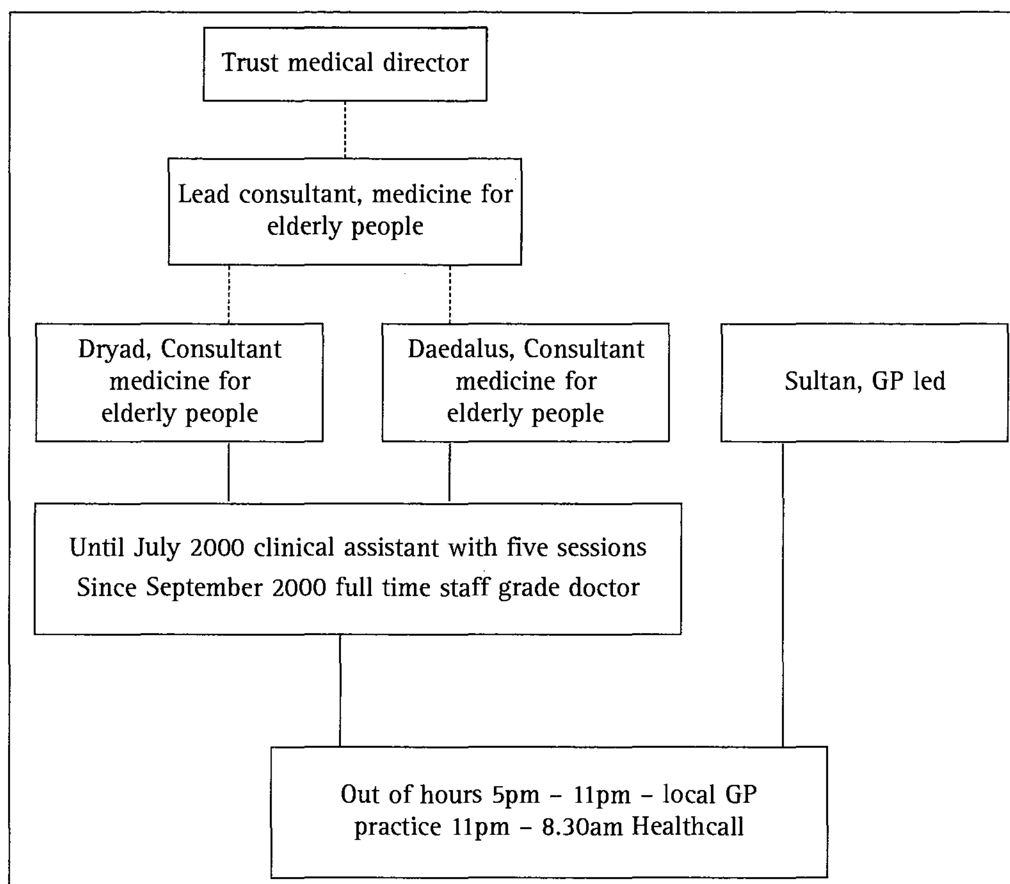
Medical responsibility

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.

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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.

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
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B) DOCUMENTS RELATING TO PORTSMOUTH HEALTHCARE NHS TRUST

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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.

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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

- **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

- **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

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.

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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).

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.

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

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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.

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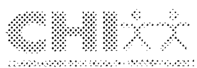

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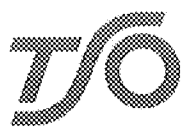

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Investigation into the Portsmouth Healthcare NHS Trust

Gosport War Memorial Hospital

JULY 2002

CHI
COMMISSION FOR HEALTH IMPROVEMENT

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- 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

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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 ap poor prescribing practice was not identified
- there was a lack of thorough multidisciplinary total pa determine care needs on admission

CHI also concludes that the trust now has adequate policie which are being adhered to governing the prescription anc relieving medicines to older patients.

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- 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.

Not look at individual complaints or conduct...

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.

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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 concern reviewed the prescribing practice of one local GP This was communicated to the trust.

2.11 In July 2001, the chief executive of the health author NMC – considering obtaining a source of expertise in order to reestablish pub case for older people in Gosport. This was at the same time as

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June 01 – HA voluntary local procedure
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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.

Wards & beds

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.

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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 report[illegible] investigation and CHI cannot take any respon[illegible] the reports provided CHI with very useful inform[illegible] independent scrutiny of data and information [illegible] it to reach the conclusions in this chapter.

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- 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.

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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 1.

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.

Diamorphine, haloperidol, Midazolam – peak in 98/99

Concerns ↑ use + practice of anticipatory prescribing

CHI use : excessive + outside normal practice

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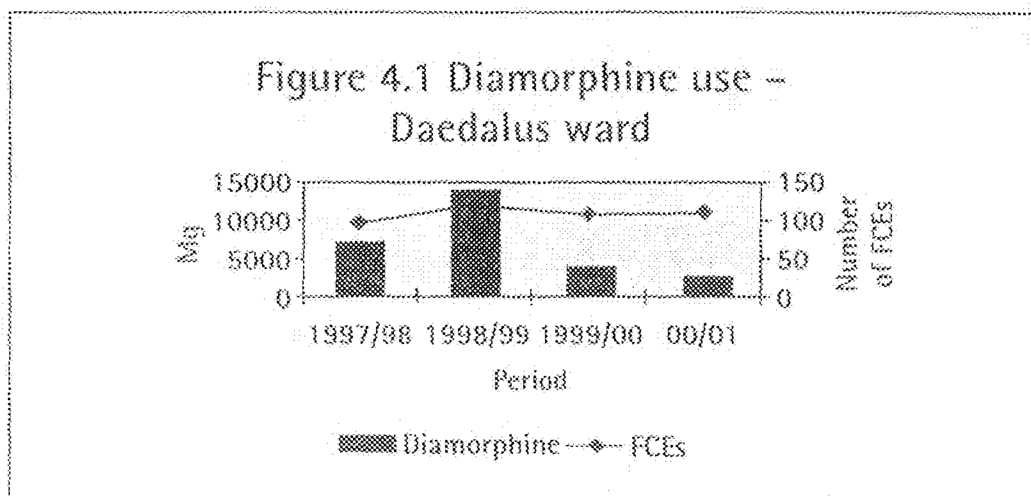
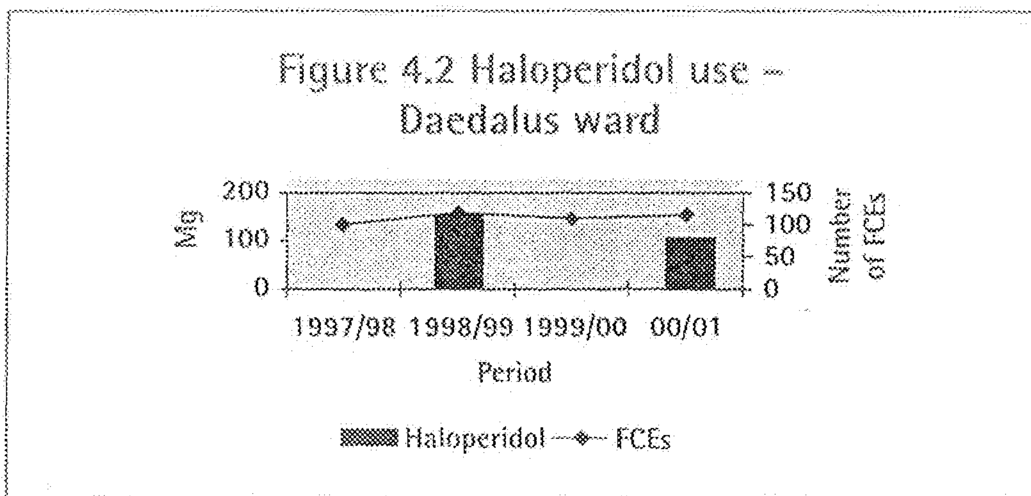
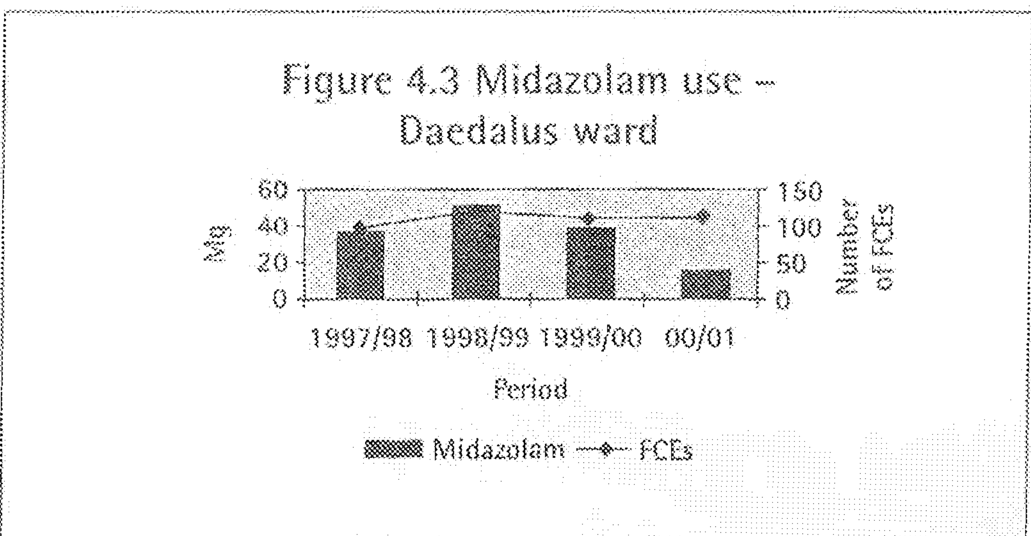
Medicine issued 1997/1998–2000/2001 according to the number of finished consultant episodes per ward, based on information provided by the Portsmouth Healthcare NHS Trust (see appendices H and I)







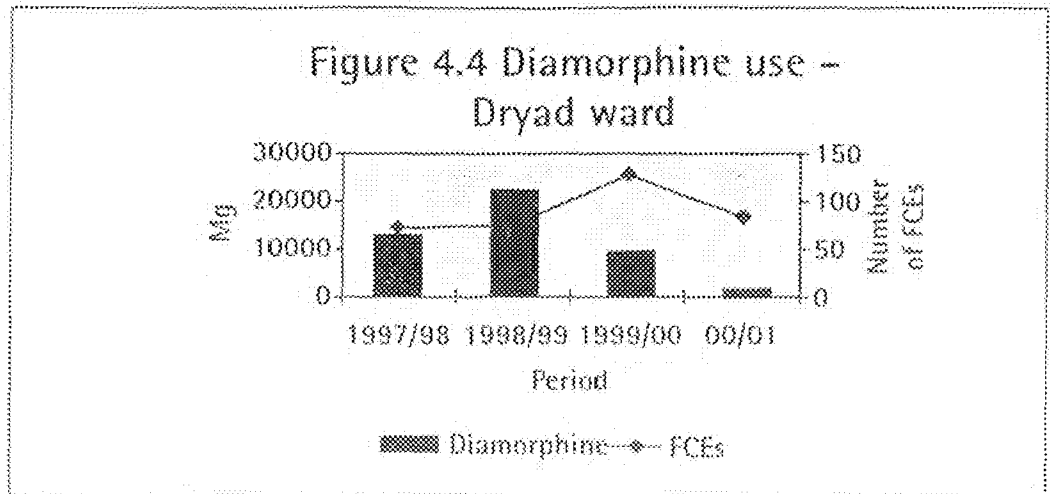


Figure 4.4 Diamorphine use - Dryad ward
30000
20000
10000
0
Mg
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Diamorphine FCEs

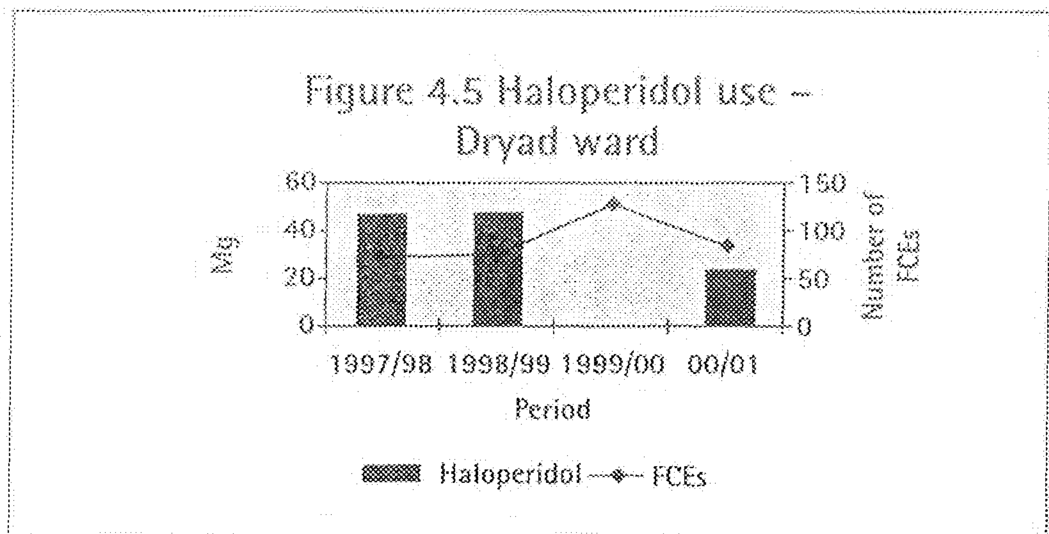


Figure 4.5 Haloperidol use - Dryad ward
60
40
20
0
Mg
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Haloperidol FCEs

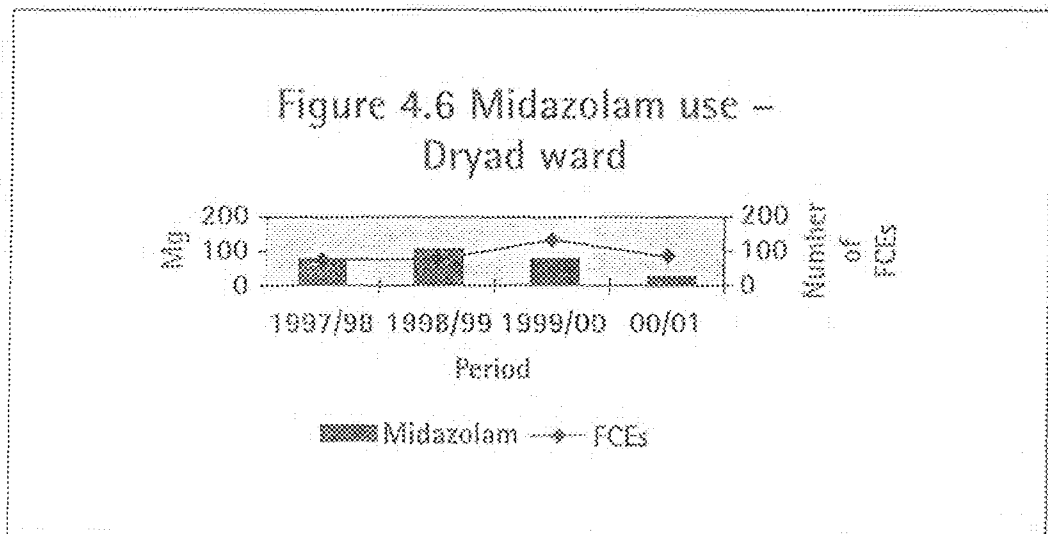


Figure 4.6 Midazolam use - Dryad ward
200
100
0
Mg
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Midazolam FCEs

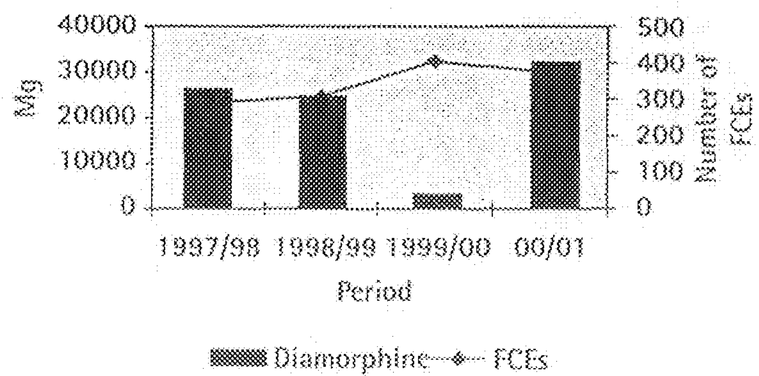


Figure 4.7 Diamorphine use – Sultan ward
40000
30000
20000
10000
0
Mg
500
400
300
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Diamorphine
FCEs

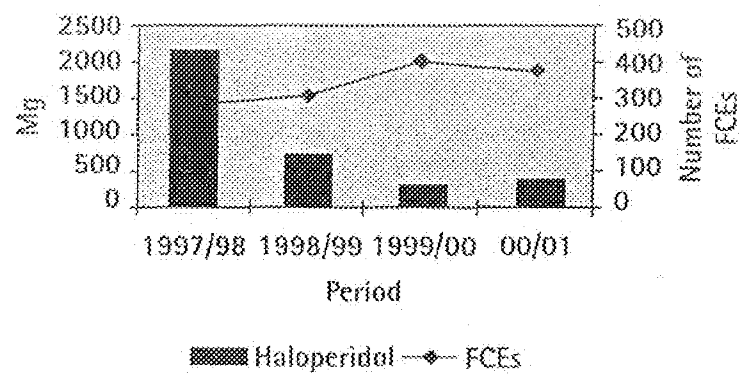


Figure 4.8 Haloperidol use – Sultan ward
2500
2000
1500
1000
500
0
Mg
500
400
300
200
100
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Period
Haloperidol
FCEs

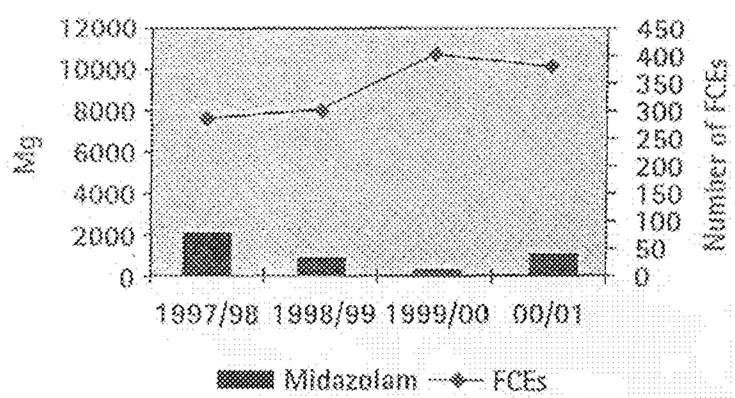


Figure 4.9 Midazolam use – Sultan ward
12000
10000
8000
6000
4000
2000
0
Mg
450
400
350
300
250
200
150
100
50
0
Number of FCEs
1997/98 1998/99 1999/00 00/01
Midazolam
FCEs

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.

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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 th[illegible] should be found to ensure that effective and regular reviews of patient me[illegible] 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.

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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".

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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.

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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.

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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.

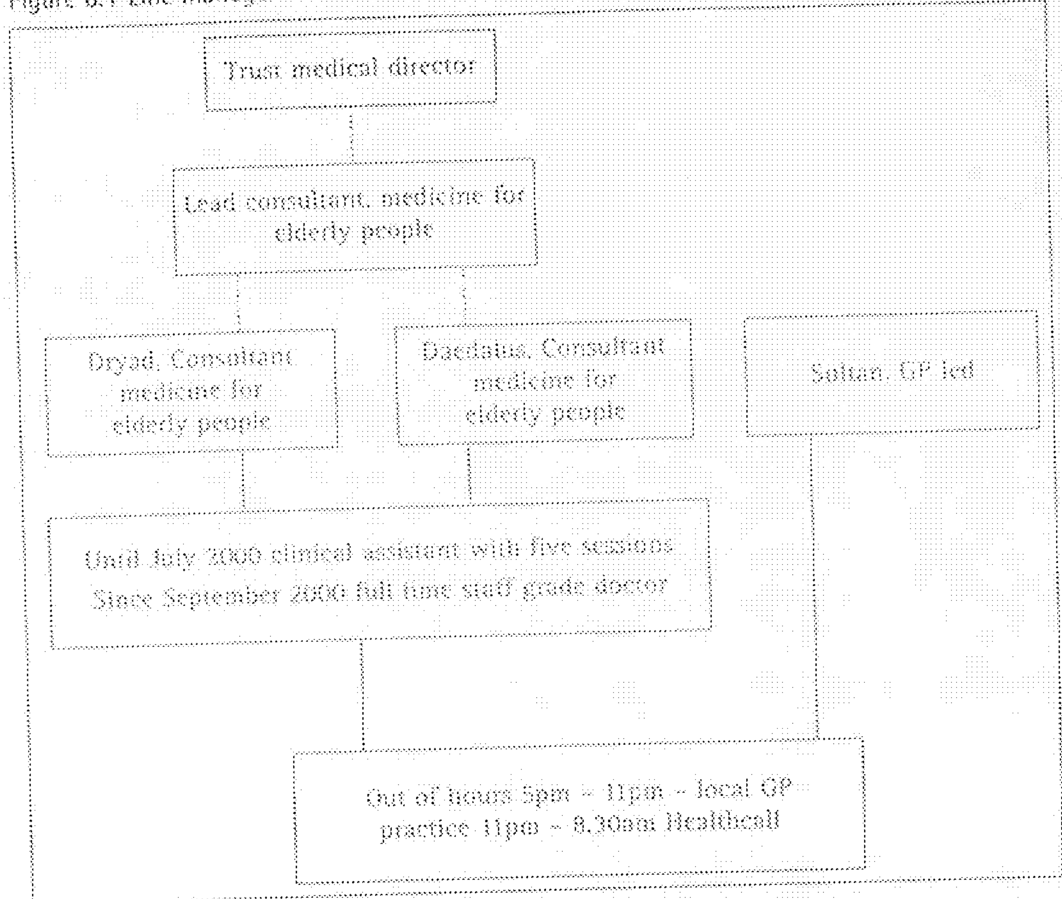
Medical responsibility

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.

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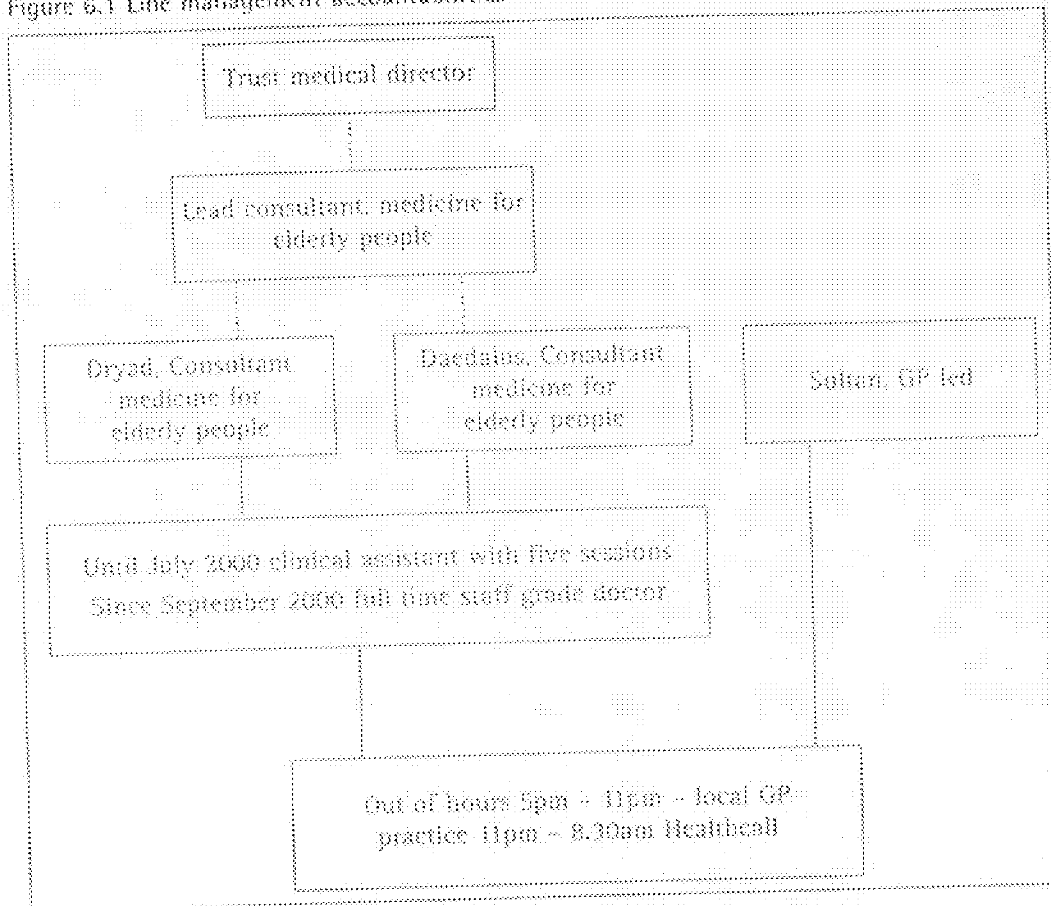

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6.7 From 1994 until the resignation of the post holder in July 2000, a clinical assistant was employed for five sessions at the Gosport War Memorial Hospital. The fees for this post were in line with national rates. The job description clearly states 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 cl[illegible] disciplinary procedures.

x supervision
x formal lines of communication
– long working hours
: lack of monitoring of clinical assistants

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 accountability 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.

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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.

[illegible]

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.

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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 difficulty 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.

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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.

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.

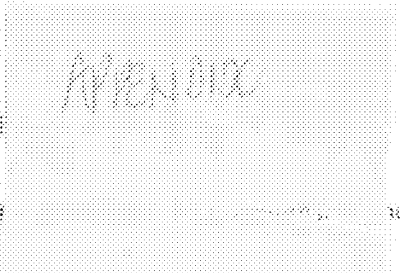
3. Clinical governance systems must be put in place to regularly identify and monitor trends revealed by risk reports and to ensure that appropriate action is taken.

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



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2. 'Measuring disability a critical analysis of the [illegible] [illegible]erapy and Rehabilitation, April 2000, Vol 7, No 4
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4. Guidelines for the administration of medicines, (including press statement) United Kingdom Central Council for Nursing, Midwifery and Health Visiting, October 2000
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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

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Qu at top of list: please can you advise whether the included documents were in existence in 1998?

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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

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6. Gosport War Memorial Hospital key objectives 2000/2001, 1998/1999, 1997/1998 and 1996/1997, Portsmouth Healthcare NHS Trust
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13. Fareham and Gosport locality division structure diagram, Portsmouth Healthcare NHS Trust, 25 October 2001
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15. Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
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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
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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
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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
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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

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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

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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

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62. Analysis of complaints at Gosport War Memorial Hospital, workshop notes and action plans, February 2001

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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

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3. Clinical Governance, Audit 1998/1999 & Summary report, District Audit, December 1999

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.

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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

(33) ✓ 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

(35) ✓ Sally Clark, Patient Transport Manager

(34) ✓ Julie Sprack, Senior Nurse

(7) ✓ Jeff Watling, Chief Pharmacist ✓ - gave us the pharmaceutical detail

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

(38) Nicky Pendleton, Progamme Lead for Elderly Care Services ✓

- NHS Executive south east regional office

Dr Mike Gill, Regional Director of Public Health

(47) { 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

(53) Robin Clarke

- Hampshire Constabulary

Detective Superintendent John James

- 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

- 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

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.

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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).

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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	38	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	37	15	7
	Dryad	30mg	5	34	51	40	4
	Sultan	30mg	5	67	40	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	3	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.

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.

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Field Fisher Waterhouse Green File

Document	Relates to
FFW monthly updates	
Barton response to PPC	Various
PPC Minutes	
Investigation Report	
Documents Rec'd from GMC re previous concerns, including:- - Letter of complaint from Mrs Batson re Velma Gilbertson with response - Letter of complaint from R Carby re Stanley Carby to GMC with response - FFW Correspondence file.	

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: MSL/TL/00492-14742/2813917 v1
Your ref: FPD/LQ/2000/2047

Linda Quinn
Conduct Case Presentation Section
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London W1W 5JE

25 May 2004

Dear Linda

Dr J A Barton

Thank you for your letter of 18 May 2004 enclosing correspondence with the police in connection with Dr Barton's case.

With reference to your final paragraph, and the disclosure of the IOC transcript to me, my understanding at present is that the police are not seeking disclosure of this document and therefore I am under no obligation to the police.

I have spoken to Detective Superintendent Steve Watts, who is leading the investigation. He has endorsed the GMC's initiative in taking advice in respect of disclosure as he believes it will be of assistance to all parties to receive an independent opinion.

I look forward to updating you once Leading Counsel has advised on this issue.

Yours sincerely

Code A

Matthew Lohn
Partner

Code A

attendance note

Name: Judith Chrystie	Call type: Telephone call
Att: Linda Quinn	From:
Duration:	Date: 5 December 2003

Hampshire Constabulary – Operation Rochester

JZC receiving an urgent call from Linda Quinn.

Linda advising that she was anxious to get hold of a report by Richard Baker which she understood was commissioned by the Chief Medical Officer. Linda needed the report urgently and was slightly panicked. Linda querying whether we (meaning the GMC) had access to the report. Linda appreciating that she understood that FFW were no longer acting for the GMC in this matter.

JZC advising that, as a result of her meetings with Hampshire Police whilst her and Michael Keegan were working on the case and through to Spring 2003, she understood that Richard Baker had been commissioned by either the police or the Chief Medical Officer in respect of the whole situation. The report had not been commissioned by the GMC and FFW had not received a copy of the report whilst acting for the GMC.

Linda advising that she had hoped to speak to Matthew in order to get hold of a copy of the report. Stating that, before she went on leave, she had received a letter from Steve Watts referring to the report. She had not taken action on this letter. Advising that Paul Phillip had now received a letter from the CMO indicating that he wished to discuss the Barton case in light of the Baker report. Paul Phillip was anxious to obtain a copy of the report.

JZC advising that, from a GMC perspective, she was unable to provide a copy of the report as this had never been passed through to her whilst GMC solicitors. JZC advising that she was not working on the Hampshire Constabulary file with MSL. MSL was currently absent from the office. She would check the file, if Linda wished her to do so, to see if we had a copy of

FIELD FISHER WATERHOUSE

attendance note

Name:	Judith Chrystie	Call type:	Telephone call (received)
Att:	Linda Quinn	From:	
Duration:		Date:	30 September 2003

Dr. Barton

JZC receiving a call from Linda Quinn of the GMC. Linda advising that she was advising that JZC had come back into the office after two weeks break. Stating that she wished to, however, discuss the Barton case as she had received a call from Hampshire Constabulary on Monday requesting a meeting and that the meeting had taken place that morning.

Linda Quinn querying what the regular updates from the police JZC was receiving referred to and whether JZC had obtained these in writing or over the phone. JZC advising that initially the updates had been in the form of a meeting and that, subsequently, JZC had telephoned the police. Advising that in latter months updates had been provided by Matthew Lohn who was acting for Hampshire Constabulary.

Linda Quinn stated that she had not recognised that Matthew was actually acting for the police. Linda indicating that although Matthew had phoned her to request the IOC transcript, he had not indicated that he was acting for Hampshire Constabulary. JZC querying this proposition as she had specifically indicated to MSL the GMC's position regarding the IOC hearing transcript. Linda Quinn stating that it may be that she had not recognised the situation properly and advising that she had been advised by Jackie Smith that Matthew was involved in discussions with the police. She had not, however, appreciated the extend to which FFW were liaising with Hampshire Constabulary.

JZC advising that there was no conflict situation in the position. Linda Quinn agreeing and indicating that the GMC would not wish to hinder the police investigation in any way.

Miss Quinn stating that she had indicated to the police that she required a written request before the IOC hearing transcript could be released so that a paper trail was evident on the file. JZC advising that she had e-mailed MSL to confirm this point and, therefore, she was content that, as the GMC's

solicitor in this matter, there was a paper trail on our file. Linda indicating that one of the matters that concerned her was a request by the police that the GMC did not advise Dr. Barton that the transcript had been passed through to them. Linda Quinn stating that this appeared unusual and she was concerned that she would not be able to tell Dr. Barton. JZC advising that the key would be public interest. Stating that if a written request was made by the police for the IOC transcript and this was accompanied by a request for the transcript not to be passed to Dr. Barton then, provided reasons were given by the police, such as advising Dr. Barton could prejudice their investigation, she would have no difficulty in advising the GMC that it was in the public interest for them to both pass the transcript and not indicate to Dr. Barton that this had been disclosed.

Linda Quinn indicating that she did not anticipate a written request being made by the police.

JZC indicating that the last update she received from Matthew Lohn was that a meeting of the experts had been held over a weekend approximately two weeks ago. JZC advising that she did not, however, know the position following the meeting. Linda advising that she had been updated in this regard – although commenting that the police had necessarily been circumspect with the information they supplied. Linda advising that five different experts had report to the police and that concern had been raised in 25 of the 65 cases considered by the expert (this amounted to approximately 15 cases). The police now intended to concentrate on the 15 cases and would appoint further experts to look at these mattes in greater detail. JZC advising that Steve Watts (from Hampshire Constabulary) had described the 15 cases as raising "*grave cause for concern*". It appeared that the experts would report that there may be negligence and that there was concern as to the cause of death.

Linda indicating that, apparently, the police would be unlikely to be in a position to interview Dr. Barton until January 2004. They were, however, continuing to liaise with Dr. Barton's solicitors and were keeping communication with Alexander Harris (the solicitors acting for the family).

Linda indicating that there may be a possibility of information being provided to allow the GMC to refer the matter back through to the IOC. JZC stating that she had flagged this issue up with the police previously and one of the difficulties would be regarding disclosure. Linda indicating that it may be possible for the police to provide a summary but that Hampshire Constabulary were conscious of the disclosure issues and the GMC's requirement to pass any documents considered by the IOC panel through to the doctor in advance.

Linda confirming that the GMC did not wish to block a police investigation and reiterating that she was concerned that she was unaware of the relationship between Matthew and Hampshire Constabulary. JZC indicating that as solicitor for the GMC she was content that there was no conflict at present but suggesting to Linda that it may be appropriate for her to formalise the position over e-mail or in a letter. JZC advising that she would discuss this matter with MSL in the next few days and revert to Linda on this point. Linda indicating that she would appreciate the matter being formalised so that a record could me made on the file of the position. Linda noting that the matter may not come through for, say, three years or so at which point it would be valuable to have the position formalised on file.

the report but it would be necessary for us to obtain Hampshire Constabulary's instructions before releasing a copy of the report to the GMC.

JZC suggesting that, as the CMO had emailed Paul Phillip directly and, moreover, as Steve Watts (of Hampshire Constabulary) had written to Linda Quinn directly, it would be entirely appropriate for Linda Quinn to contact Sean Watts directly to request a copy of the report.

Linda indicating that she was reassured that the GMC had never received a copy of the report and querying when the report may have been completed. JZC advising that she considered that the report would only have been prepared recently. It had been commissioned towards the beginning of last year and, her understanding was that it would only have been in the last few months that the report had been completed.

Linda stating that she was happy to approach Steve Watts directly.

JZC

File note

2000/2047 - Dr J A Barton

Meeting with police on 30 September 2003

Present: Detective Chief Superintendent Steve Watts
Detective Constable Nigel Niven
Linda Quinn

1. I was contacted by DCS Steve Watts of Hampshire Constabulary on Monday afternoon, 29 September 2003. He said that he and a colleague wished to meet with me to give me some information about Dr Barton. We agreed to meet Tuesday morning, 30 September 2003.

2. The meeting commenced with DCS Watts outlining the background to the police investigation of the case and saying that, following the disclosure by Hampshire and Isle of Wight HA of the 1991 file of correspondence in September 2002, the police decided to investigate all the deaths on patients under Dr Barton's care at Gosport War Memorial Hospital.

3. A team of five medical experts was appointed – experts in the fields of toxicology, geriatric medicine, palliative care, general practice and nursing. The experts have now reported on the basis of whether the treatment provided to each of the 62 patients was optimal, sub-optimal, or negligent; and whether the reason for death/harm was natural causes, unclear, or unexplained by natural cause/disease.

4. The medical experts' findings are:

Optimal	25% (approximately)	
Sub-optimal but causation unclear	50%	"
Negligent, cause of death unclear	25%	"

(DCS Watts said these give grave cause for concern)

5. Matthew Lohn has been appointed by the police to run a quality control check on these findings. I understand that they will not become final conclusions until that check is complete.

6. The police will then appoint further experts to examine in detail the 25% of cases (some 15 or 16) which fall into the category of "negligent, cause of death unclear".

7. The police will not interview Dr Barton until the second team of experts have reported, and they expect this to be January 2004 at the earliest.

8. The police have informed Dr Barton's solicitor (Ian Barker of MDU) that they are concerned about a significant number of cases, but have not conveyed actual numbers.

9. They also keep the families informed, through Alexander Harris, and on Friday, 3 October 2003 they are meeting with someone from the strategic health authority to update them on the investigation.

10. The police asked LQ the case would be reconsidered by the IOC on the basis of the information they were supplying. They fully understood that any papers which were to be seen by IOC would also be disclosed to Dr Barton and her solicitor. They emphasised that they were not able to provide full details of their investigations because this could jeopardise their further investigations and their eventual interview of Dr Barton. However, DCS Watts said they would be able to provide a brief written summary of the current position if we so required. We would have to request it in writing, explaining they reasons for it and why it was in the public interest for the police to supply it, and what action we envisaged taking.

Linda Quinn
30 September 2003

Chrystie, Judith

From: Chrystie, Judith
Sent: 01 October 2003 19:27
To: GMC - Linda Quinn (7344 3760)
Subject: RE: Dr Barton

Hi Linda

Many thanks for the email and the attachments. It is extremely helpful to have your notes for the file.

Perhaps we can further discuss the matter next week?

Thanks again!

Kind regards
Judith

-----Original Message-----
From: Linda Quinn (7344 4700) [mailto Code A
Sent: Wednesday, October 01, 2003 10:17 AM
To: Code A
Subject: Dr Barton

Hi Judith

Further to our conversation yesterday, I attach a copy of my note of my meeting with the police, the memo I sent to Paul Philip, and a copy of the email I sent to Peter Steel (one of our Principal Legal Advisers) after my conversation with Matthew. The latter two are to keep you in the picture really, but if you have any comments, please let me know. As I said yesterday, following discussion with Peter Steel I informed Matthew that we could agreee the police request not to tell Dr Barton if we released the transcript, but that, as already stated by us, we required the request for the transcript in writing, direct from the police.

<<mtg-police-30sep03.doc>> <<pp&js memo30sep03.doc>> <<Dr Barton>>

Linda

Memorandum	**To**	**Paul Philip**
	From	**Linda Quinn**
	Date	**30 September 2003**
	Copy	**Jackie Smith**

Dr J A Barton (2000/2047)

1. I have today met with two officers from Hampshire Constabulary who sought the meeting in order to update the GMC on the progress of their investigations.

2. I attach my note of the meeting at flag A, and for background, I attach a copy of a memo dated 13 September 2002 at flag B.

3. Consideration needs to be given to whether the information supplied by the police this morning (plus the written summary they could provide if asked) is sufficient fresh information for the matter to be referred to IOC.

4. I note from the casefile that when we initially received the 1991 information in September 2002, it was not considered sufficient to go back to IOC with (Peter Swain's email of 24 September 2002 - flag C).

5. However, the police have now had 62 cases involving Dr Barton analysed by a team of experts, and the finding in some 15 or 16 cases are "negligence, cause of death unclear".

6. As can be seen from paragraph 5 of my note, the results are to be quality checked.

7. If the case is to be reconsidered by IOC in the light of new information, it will be necessary to decide whether this should be done after the quality check on the first set of experts' findings, or whether it should be done after the second set of experts report to the police (possibly January 2004).

8. Dr Barton's case has been considered by IOC three times so far, and in each case no order was made.

9. The police are updating Alexander Harris (for the families) this afternoon, and the strategic health authority on Friday 3 October 2003. These updates may generate inquiries to the GMC.

Chrystie, Judith

From: GMC - Linda Quinn (7344 3760)

Sent: 19 September 2003 12:55

To: Peter Steel (7915 3589)

Subject: Dr Barton

Peter

I expect you are aware of this case. Very briefly, there is a police investigation into her prescribing of opiate/sedative drugs to elderly patients in hospital. A number of allegations were referred to PCC by PPC on 29/30 August 2002, but GMC investigation is on hold because of police inquiries.

The case was originally Michael Keegan's, and in January 2003 there was some email discussion about disclosure of documents to the police. Some were disclosed, but they wanted a copy of the IOC transcript from September 2002 (no order was made). Michael asked that the Police make a formal, reasoned request for this document, and the request would then be considered at a senior level in the GMC.

It seems that nothing further happened at the time. I have now been asked by FFW to let the police have the transcript. I said I would need the request in writing, and FFW told the police this. The police have now asked FFW to ask the GMC to confirm that it would not tell Dr Barton of their request.

I discussed this with Matthew, who is dealing with the police. He said that because Dr Barton was at the IOC hearing, it is OK to disclose the transcript to the police because she knows what happened at the hearing. But this didn't fit with the police request as far as I could see - the police were asking that the doctor not be told that we were disclosing the document. Matthew said there was no inequality to Dr B in terms of the GMC's function as a regulator in disclosing the transcript.

The reason for the police request not to tell Dr B is that the investigations are at a very sensitive stage.

I assured him that neither I nor the GMC wished to obstruct the police in ther investigation, and said I would get back to him.

Could you possibly advise me. I assume that we would disclose at the police's request, but is it OK not to tell Dr Barton that we are disclosing the transcript?

Linda

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

TRANSMISSION OK

TX/RX NO 3646
CONNECTION TEL 902079153696
SUBADDRESS
CONNECTION ID
ST. TIME 10/09 19:22
USAGE T 01'10
PGS. SENT 5
RESULT OK

FIELD FISHER WATERHOUSE

fax

To:	Linda Quinn	Fax:	020 7915 3696
At:	General Medical Council	Pages including this one:	5
From:	Judith Chrystie	Date:	10 September 2003
Copy:		Fax:	
Our ref:	JZC/00492-14742/2486013 v1	Your ref:	Barton

The information contained in this fax is confidential and may be legally privileged. It is intended only for the addressee. Rights to confidentiality and privilege are not waived. If you are not the intended recipient, please advise the sender immediately; any disclosure, copying or distribution is prohibited and may be unlawful.

Dear Linda

Dr J Barton

Following our telephone conversation today, please find attached:

1. My letter to Michael Keegan dated 9 January 2003;

2. Email from Michael to me dated 15 July 2003.

FIELD FISHER WATERHOUSE

fax

To:	**Linda Quinn**	Fax:	**020 7915 3696**
At:	**General Medical Council**	Pages including this one:	**5**
From:	**Judith Chrystie**	Date:	**10 September 2003**
Copy:		Fax:	
Our ref:	**JZC/00492-14742/2486013 v1**	Your ref:	**Barton**

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Dear Linda

Dr J Barton

Following our telephone conversation today, please find attached:

1. My letter to Michael Keegan dated 9 January 2003;

2. Email from Michael to me dated 15 July 2003.

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 **Fax** +44 (0)20 7488 0084 **e-mail** info@ffwlaw.com **london@thealliancelaw.com**
www.ffwlaw.com www.thealliancelaw.com **CDE** 823
London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

Regulated by the Law Society. A list of the names of the partners of FFW and their professional qualifications is open to inspection at the above office.
The partners are either solicitors or registered foreign lawyers.
The European Legal Alliance is an alliance of independent law firms

I am waiting for a written request from, or on behalf of, Hampshire Constabulary for a copy of the IOC transcript dated 19 September 2002 to be released to them for use in the criminal enquiries.

Whist we are waiting, please could you arrange for a new transcript to be obtained. As I explained during our telephone discussion today, page 12 in the document sent to us relates to an entirely different matter!

Kind regards

Code A

Judith Chrystie
Assistant Solicitor
Code A
Email: jxc@ffwlaw.com

Chrystie, Judith

From: Chrystie, Judith
Sent: 16 January 2003 13:46
To: 'Michael Keegan (7915 7437)'
Subject: RE: Dr Barton

Dear Michael

Many thanks for your email. Sorry for the delay in responding: I have been over at CHI.

I will update you next week as to the documents and information CHI held and any information DI Niven passes to me on Tuesday. I will also ask him to make a formal request to us for the release of papers (I suggest that the request is comprehensive to include all the papers we hold - even those that you are content to release now - for the sake of consistency).

See you at 2pm on Wednesday!

Kind regards
Judith

-----Original Message-----
From: Michael Keegan (7915 7437) [mailto Code A]
Sent: Wednesday, January 15, 2003 4:39 PM
To: Judith Chrystie (E-mail)
Subject: Dr Barton

Dear Judith,

I have had a chance to speak about disclosure to the Police of the IOC transcript in this case and consequently advise that the Police should make a formal, reasoned request for the same. That request can then be considered at a senior level. This is, as you can imagine, in light of both the sensitivity of this case and the lack of precedent of which we are aware.

I should be grateful if you would communicate this to DI Niven.

Regards

Michael Keegan
Conduct Case Presentation Section
Code A

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FIELD FISHER WATERHOUSE

Our ref: JZC/HJA/00492-14742/2180712 v1
Your ref: MK/2000/2047

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

9 January 2003

Dear Michael

Dr. Jane Barton

I refer to the above matter.

Since my letter through to you dated 17 December 2002 I have attempted to forward the missing enclosures through e-mail. Each time I have done so a few days later I receive an indication that the documents have not been received with you! My last effort was on 24 December 2003 and I returned to the office yesterday – my first day back in the office since the Christmas break – to find another rejection advice.

I have checked the e-mail carefully and am using the following address: Code A. I wonder if the documentation I am supplying occupies too much 'space' to be allowed through the GMC's firewalls. As technology has failed me, I enclose hard copy versions and apologise for the earlier omission.

As I indicated, a copy has been forwarded through to Detective Inspector Nigel Niven. Nigel has indicated that they wish to clarify certain aspects of the note. I await his amendments for inclusion in the note and for discussion with you.

As you are aware, John and I are scheduled to attend at the offices of CHI next week and we shall update you at our meeting on 22 January 2003. Would a time of 2.00pm be suitable for you? Unless I hear from you to the contrary, I look forward to meeting with you again then at our offices.

Field Fisher Waterhouse
Tel Fax e-mail london@thealliancelaw.com
www. www.thealliancelaw.com CDE
London

In your letter dated 18 December 2002 you request my thoughts on the inclusion of Mr Carby's complaint under a Rule 11(2) referral. I thought that I had addressed this issue with you at our pre-meeting on 20 November 2002 at which I indicated that the other matters received by the GMC did appear appropriate to be considered under Rule 11(2).

I do not, however, consider that it would be appropriate for us to undertake any investigation at the moment as this may prejudice the enquiries being undertaken by Hampshire Constabulary. To determine definitively whether the complaint should go through to the PCC (if, indeed, we end up following a charge of serious professional misconduct as opposed to a criminal conviction), further enquiries will need to be undertaken and expert evidence obtained to determine the exact validity of the complaint.

One of the issues mentioned at our meeting in November was whether the police should receive all documentation the GMC hold in relation to this matter. My initial advice to you was that it would be appropriate for the material, in particular the documents considered by the PPC, the letters received on behalf of Dr. Barton, the transcript of the IOC hearing and the additional papers received regarding the incident in 1991 to be disclosed. I confirm this advice. Within the Medical Act 1983 (as amended) the GMC made disclose "*to any person any information relating to a practitioner's professional conduct, professional performance or fitness to practise which they consider it to be in the public interest to disclose*" (Section 35B).

Are you content that it is in the public interest to disclose the material I have identified above? Should you confirm that the GMC consider it to be in the public interest, I shall pass the relevant documentation through to Detective Inspector Niven.

I hope that you had a restful Christmas and New Year break and that the move into your new home went smoothly.

See you next week!

Kind regards,

Yours sincerely

Code A

pp Judith Chrystie

Code A

Matter BARTON Date 10/09/03

Attending Linda Quinn

Telephone Call | IN | OUT | In Person | |

- Call to Linda – indicating that we had received formal request for IOC transcript from Hampshire Constabulary – could JLC release?

- Linda querying whether request was in writing etc. She felt that there should be a paper trail – even couple of lines

Action to be taken

Time occupied .... Initials ....

JLC to check. JLC to email ~~exchange~~ last exchange of emails on issue with Michael Keegan (PTO)

TLC advising that page 12 to copy transcript we held was related to another matter — Linda would obtain further copy.

Chrystie, Judith

From: Chrystie, Judith
Sent: 07 May 2003 15:24
To: GMC - Linda Quinn (7 Code A
Subject: RE: Dr J A Barton

Dear Linda

Thank you for your email. Sorry for the delay in responding - I am afraid I returned from holiday with the lurgy!

You are right: the GMC have agreed to hold the professional conduct investigation in abeyance pending the completion of the criminal enquiries and any subsequent prosecution.

I am in relatively regular contact with the police and let you know what information I glean from Hampshire Constabulary - particularly concerning timescales and progress. I am also - with the Constabulary's permission - liaising with CHI.

Kind regards
Judith

-----Original Message-----
From: Linda Quinn (7344 4700) [mailto Code A]
Sent: Friday, May 02, 2003 2:19 PM
To: Code A John Offord
Subject: Dr J A Barton

Hello

Just to let you know that I have inherited this case now that Michael Keegan has joined the Committee Development Team.

I have had a look at the latest correspondence and the PPC papers, and had a word with Michael. I understand that nothing is happening on the GMC case because we await the outcome of police investigations.

Please keep me updated!

Linda

GMC100942-0484

Chrystie, Judith

From: Linda Quinn (7344 4700) Code A
Sent: 02 May 2003 14:19
To: Code A John Offord
Subject: Dr J A Barton

Hello

Just to let you know that I have inherited this case now that Michael Keegan has joined the Committee Development Team.

I have had a look at the latest correspondence and the PPC papers, and had a word with Michael. I understand that nothing is happening on the GMC case because we await the outcome of police investigations.

Please keep me updated!

Linda

Chrystie, Judith

From: Chr y ie, Judith
Sent: 15 A   l 2003 12:53
To: Code A
Subject: Atten ance note - 21/01

Second note for your r   s.

Judith Chrystie
Professional Regulator
Code A

Docs_2223853_1.DOC

Chrystie, Judith

From: Chr[illegible]e, Judith
Sent: 15 A[illegible]l 2003 12:53
To: Code A
Subject: Attend[illegible]nce note - 05/02

Docs_2223570_1.DOC

As prom[illegible]

Judith Chrystie
Professional Regulatory [illegible]
Code A

Matter BROWN Date 15/04/03

Attending Nigel Niven

Telephone Call	IN	OUT	In Person	

Call to Nigel Niven

Speaking with NN

NN asking if he could call TJC back as he was 'in the middle' of a 'something'

Action to be taken

Time occupied .... Initials ....

Matter BARTON Date 15/04/03

Attending Nigel Niven, Hampshire Constabulary

Telephone Call IN ✓ OUT In Person

Call from Nigel Niven : Update –

Forensic team – 26/04/03 next meeting

↓

Able to gauge how long will take

Looking at first 20 patients

All records are on DVD

Action to be taken

Time occupied .... Initials ....

Are interviewing the clinical staff.

Background stuff being done.

JLC to send stuff docs down in May.

Chrystie, Judith

From: Chrystie, Judith
Sent: 15 April 2003 12:51
To: 'Michael Keegan (7915 7437)'
Subject: RE: Dr Jane Barton

Hi Michael

I have been out of office other work matters until today s es for the delay in responding.

I have not had any ther sub tantive meetings with the police. he process of arranging a weekend with their perts o 26 April 2003 regarding the exper and will try to get an update for the new case worker that da . The police say that this meeting e them a good indication about timescales.

In this regard, however, I und stand that the police hope to be i on to determine whether and how to proceed towards t end of t year.

I am conscious th ere are number of other non-urgent mat s ed to attend to on the file, notwithstanding, act that matter cannot proceed rtly. the pressures of other work and the fact that these low pri ty, I am afraid that I have yet to f I shall endeavour to do so after Easter.

I shall, in two sep emails send you the meeting note from ng with the police in January and with you in Februa which I 't think you have for your file. I d them separately owing to the difficulties we hav experien previously - please let me know do not arrive.

I shall be out of the ffice from ater today until 1 May on annual

Good luck in the post! P se can you let me know who ta task of taking over the matter from you!

Kind regards
Judith

-----Original Message-----
From: Michael Keegan 7915 7437) [mailto **Code A**
Sent: Friday April 11, 2003 12:55 PM
To: Judith Chrystie (E-mail)
Subject: Dr Jane Barton

Dear Judith

I will be leaving the Conduct Case Presentation Section o 2 ril 2003.

As part of ort to ss files over to colleagues in a r tidy format I was going to write to the atives of tients whose cases we are inve , or to Messrs Alexander Harris on behalf.

I should be ateful to ow, therefore, whether you have contact with the Police further to our last meeting on January. Is there any timescale completion of Police inquiries that I could in ude in my letters to relatives and the colleague who inherits this case?

Thanks for help i is case. I'm staying with the GMC a you'll probably see me again sooner or

Kind Regards

Michael Keegan
Conduct Case Presentation Section

Code A

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FILE COPY

Our ref: JZC/KAB/00492-14742/2208078 v1

Ms Julie Miller
Commission for Health Improvement
Finsbury Tower
103-105 Bunhill Road
London EC1Y 8TG

29 January 2003

Dear Julie

General Medical Council - Dr J Barton

I write to thank you and Kelly for your hospitality and assistance during the time John Offord and I spent with you examining the documents CHI holds in relation to Gosport War Memorial Hospital.

I was extremely impressed with the organised way in which your files were retained and this made the exercise in examining the documents much easier.

As you are aware, I was due to meet with Hampshire Constabulary and the GMC last week in order to determine how best to proceed on the following issues:

1. Request for copies of various witness statements held by CHI.

2. Contacting Dr Barton regarding her interpretation of the fact that the GMC's Interim Order Committee (IOC) did not impose an interim order on her registration.

In respect of the first issue I am aware that you wish to write to the witnesses in order to advise them that their statement have been transferred to the GMC. During my meeting with Hampshire Constabulary they indicated that they did not consider that passing the documents to Field Fisher Waterhouse or indicating to the individuals interviewed would interfere with police enquiries. I shall contact you further in this regard in the near future.

Hampshire Constabulary are anxious that the GMC or Field Fisher Waterhouse do contact Dr Barton in order to advise her that the fact that the IOC did not made an interim order could not be interpreted as demonstrating that the GMC does not consider that there is avalid criticism of Dr Barton's practice – only the Professional Conduct Committee can make this determination having heard all the evidence in the matter. Unfortunately, I was unable to take instructions on whether or how to contact Dr Barton as my meeting with the GMC was cancelled. It has been re-scheduled for 5 February 2003 following which I shall discus this matter further with the case worker on the matter, Michael Keegan.

I understand from our discussions that you will have left the CHI by 5 February 2003. I have, therefore, written this letter to update you, and your successor, as to the current position and to wish you well in your new post.

I shall contact Kelly in the near future to arrange for a courier to pick up the papers you have kindly copied for us.

Please do not hesitate to contact me should you wish clarification of any point within this letter.

Many thanks once again for your kind assistance on 14 and 15 January 2003. Please would you also pass on my gratitude to Kelly.

Kind regards.

Yours sincerely

Judith Chrystie

Code A

Solicitors to the General Medical Council

Meeting Note

	Judith Chrystie	Call type:	Meeting
Att:	**Michael Keegan**	From:	**GMC**
Duration:		Date:	**5 February 2003**

Dr Barton

JZC meeting with Michael Keegan (MK) of the GMC at FFW's offices.

The meeting was arranged in order to update MK as to the investigation that JZC and JHO had undertaken at CHI and the meeting with Hampshire Constabulary on 21 January 2003.

JZC advising that she had visited the office of CHI over two days and was assisted by JHO on one day. Advising that the documents JZC had requested in November in Appendix A of the CHI report had been copied for JZC. Explaining that JZC had only requested those documents which were in existence during the period 1998/1999. JZC advising that many of those documents were not relevant but that it was important that we had obtained copies of them.

JZC advising that CHI had interviewed a number of witnesses she and JHO had moved through each of the witnesses identified in Appendix C and D of the report. A brief summary of the nature of the statement and whether it would be valuable to interview both individuals had been made.

JZC advising that she had concerns that the CHI investigation had not specifically questioned the prescribing habit of Dr Barton, therefore, the statements were not of assistance to the GMC as they stood. Stating that the CHI investigation did, however, allow the GMC and FFW to identify those individuals who may be able to provide information of relevance and, indeed, those witnesses that had to be interviewed owing to their presence on the wards at the relevant time.

JZC indicating that Hampshire Constabulary were happy for the individuals interviewed by CHI to be notified that their statements were being passed to the GMC but that no action would be taken.

JZC advising that in addition to examining the statements she had had an opportunity to consider some of the correspondence held by CHI. Advising that one piece of correspondence was a letter from Dr Barton to the Personnel Director of Portsmouth Healthcare Trust. The letter to the Trust referred to the IOC decision not to place an interim order upon Dr Barton's registration and, Dr Barton had concluded that if "*in other words, in their [GMC] view there was no case to answer*". In addition, Dr Barton had suggested that she did not "*consider that I have done anything wrong, a view supported by the GMC*".

JZC advising that she was anxious to write to Dr Barton in order to prevent her from interpreting the IOC's decision in this way. Advising that she had spoken to Nigel Niven who had indicated that he would be happy for JZC to write to Dr Barton. JZC specifically requesting MK's instructions to do so. MK indicating that it would be appropriate for JZC to write to Dr Barton. JZC would provide a draft to MK for comments.

JZC stating that Nigel Niven had also suggested that he would be happy for the GMC to advise that the police were undertaking enquiries and, it was for this reason, that the GMC had placed their disciplinary hearing in abeyance.

JZC querying whether MK held any GP records. MK confirming that he did not have any medical records. JZC advising that the police were searching for these records and had asked JZC whether any were held by her or the GMC.

JZC advising that the police were undertaking investigations into 62 deaths based on concerns that had been raised by families of deceased relatives.

JZC commenting on the first issue for the police, in addition to obtaining the medical records, was to establish a panel of experts. JZC explaining that in addition to Professor Robert Forest the police intended to have an expert from Palliative Care, Care of the Elderly, General Practice and Epidemiology. JZC confirming with MK that we would be happy to pass on any comments to the policy about the expert they chose if we had any concerns.

JZC indicating that the task for the police was to determine causation, determine a mechanism for establishing the significance of the number of deaths and the cases causing concern and to determine whether there had been any inappropriate prescribing regime in place.

JZC querying whether the GMC had any information to indicate that Dr Barton had undertaken a course in Palliative Care. MK stating that he had checked the specialist register and she was not registered on it. JZC confirming with MK that attending a course would not be registerable matter.

JZC advising that Hampshire Constabulary had requested a letter regarding formal disclosure of documents. JZC receiving instructions from MK for her to draft a letter to Hampshire Constabulary formally asking them to formally request documents. JZC explained that she had not passed on any of the documents that MK was happy that it was in the public interest to do so as she felt it was appropriate for a formal request to be made for the documents. MK agreeing.

JZC advising MK of the suggested timescale for the police investigation and the fact that Nigel Niven hoped that his investigation would be concluded and legal advice obtained by the end of 2003.

JZC suggesting that as there was no interim work that could be done at present between meetings with FFW and Hampshire Constabulary, it may be appropriate for MK to attend the meetings with Nigel Niven. This would avoid the need to have a separate updating meeting with MK. MK agreeing that this would be an appropriate step.

FIELD FISHER WATERHOUSE

attendance note

Name: Judith Chrystie	Call type: Telephone call
Att:	From:
Duration:	Date: 23 January 2003

Dr Barton

JZC receiving a call from Nigel Niven on Code A

Detective Inspector Niven had attempted to get JZC earlier in the day and JZC apologising for being unable to speak with Nigel beforehand.

Nigel explaining that he had sent JZC an e-mail which contained his suggested amendments to her minutes. Stating that the amendments contained clarification of one or two points. If JZ|C had any issue regarding the amendments perhaps these could be raised as he was conscious that the document needed to be agreed by all parties in attendance.

Nigel explaining that he was in London in the week commencing 20 January 2002 and wondered whether JZC had time on 21 January 2003 to meet with him for an update on the case.

JZC advising that this would be excellent timing as she was meeting with CHI on 14 and 15 January and she had scheduled to update the GMC on 22 January 2002.

Nigel Niven advising that, off the record, it appeared that he Strategic Health Authority and CHI would be undertaking a further enquiry. Nigel querying the benefit of such an enquiry as he felt that it may be relating to disciplinary matters. Nigel surmising that the enquiry may be in order to prevent public critisism.

Nigel would telephone JZC or HJA in order to confirm a time for the meeting.

JZC

Meeting Note

Judith Chrystie	Call type: Meeting
Att: Hampshire Constabulary	From:
Duration:	Date: 21 January 2003

Dr Barton – Meeting with Hampshire Constabulary (Meeting No.2)

Attendees

FFW:	Judith Chryste – JZC
Police:	DI Nigel Niven – NN
	DC Chris Yates – CY

Meeting

JZC thanking NN and CY for attending FFW's office in order to provide an update as to the progress on the criminal investigation since their meeting in November 2002.

NN advising that he was happy to do so and as he had reassured JZC in November, he would continue to do so. He wished to liaise with all stakeholders involved in the matter.

NN stating that the police investigation had expanded through to 1998-1989. This was the period in which Dr Barton had started undertaking work at the Gosport War Memorial Hospital (GWMH).

CHI Investigation

JZC advising NN and CY that she and JHO had recently visited the offices of the Commission of Health Improvement (CHI) in order to examine the documents and statements that had been taken by CHI during their investigation last year.

JZC advising that there was only one statement in which concern was raised regarding the prescribing habits of Dr Barton. This was a nurse who had initiated a grievance. JZC apologising for the fact that she did not have the documentation with her at the meeting but indicating that she would send her file note of analysis to Hampshire Constabulary.

JZC advising that there were a number of individuals that she wished to interview and she appreciated that she could not do this until the conclusion of the policy enquiry. Advising that she would, however, JZC indicating that she wished to obtain copies of the statements and documents relating to those interviews. JZC explaining that CHI did not want to pass on the statements without informing the witnesses that copies of the statements had been passed to the GMC. JZC commenting that CHI had, upon taking the statements, indicated that it might be necessary to pass those through to the GMC or the police and, consequently, CHI had already identified the possibility with each witness. JZC advising, however, that Julie Miller (of CHI), did wish to advise each individual that this had happened and JZC querying whether this would affect the police investigation.

NN stating that he was entirely "neutral" as to whether the witnesses were notified that their statements had been passed to the GMC. He felt that this was an entirely reasonable request particularly as JZC was confirming that she had no intention to approach the witnesses directly or take live evidence from any individual. JZC confirming that this was the position and advising that she would copy NN into any correspondence.

IOC Decision – Dr Barton's interpretation

JZC advising that she had seen a letter from Dr Barton to the Personnel Director of the Portsmouth Healthcare Trust. This letter contained comments regarding the IOC decision not to suspend or place conditions upon Dr Barton's registration prior to the PCC hearing. JZC advising that Dr Barton suggested that the IOC decision meant that the GMC's view was that there was no case to answer and, moreover, that the GMC did not consider that she has done anything wrong.

JZC stating that this was not the decision of the IOC hearing and she wished to obtain GMC instructions to write through to Dr Barton advising her that she could not continue to make such statements as this was not the position; the IOC had determined it was not in her interests nor the public interest to make an interim order but that the PCC would decide whether there was any criticism of her practice.

JZC querying whether, if the GMC provided her instructions to contact Dr Barton, this would have any impact upon the police enquiry. NN confirming that Hampshire Constabulary had made no efforts to conceal the fact that there was an investigation. The investigation of Dr Barton had been widely flagged up in the press. It was clear that the police were seeking to establish whether a crime had been committed and, if so, by whom. NN indicating that, from his perspective, he felt that it was only right and proper to notify her that it was inappropriate to make statements interpreting the IOC decision in this way.

NN commenting that it may be appropriate for the GMC to be able to write to Dr Barton and indicate that a police investigation was continuing and, therefore, the disciplinary action would not be

advanced until the conclusion of the criminal enquiry. JZC and NN discussion the fact that this would show that the GMC were not delaying matters unnecessarily and avoid potential arguments of abuse of process. In summary, it was clear that the GMC were holding disciplinary proceedings in abeyance whilst the police were undertaking their own enquiries.

Disclosure

JZC advising that there were a number of documents that she wished to pass through to the police. These documents related to the papers that had been considered by the PPC and the IOC. Advising that the GMC had the ability under Section 35A of the Medical Act 1983 (as amended) to pass on documentation to other parties in the public interest JZC indicating that the GMC were happy that it would be in the public interest to pass the documentation through to the police but were concerned that passing on documents such as the transcript of a private IOC hearing should be a document that was formally requested by Hampshire Constabulary.

JZC and NN discussing the fact that Hampshire Constabulary would be happy to make a formal request. NN asking JZC to ask him formally for those documents.

Police Investigation

NN advising that the police were investigating approximately 62 deaths. In each of these deaths it would be necessary for experts to analyse and review the medical notes. NN advising that in respect of the deaths, the families were involved and had expressed concern about the care their relatives had received.

NN stating that he was establishing a panel of experts to meet in the next few weeks. The panel of experts would be headed up by Professor Robert Forest. In addition, he would be joined by an expert in palliative care, geriatric care, general practice and epidemiology.

JZC was asked to check with the GMC as to whether Dr Barton had completed a palliative care course. JZC queried whether the GMC would have access to this information but indicating that she would ask the question. JZC advising that such courses may not be registerable matters.

NN stating that each of the experts would have access to the patient records. It may be that these were placed on CD to allow each expert to work remotely. He was, however, hopeful that a meeting could be arranged to allow all experts to discuss the case. He anticipated that the experts report may be completed in three/six months.

NN stating that the issue of causation was an issue which would be considered specifically by the experts. In addition, the experts would be asked to look at a mechanism for analysing the deaths on a medical and a scientific basis. NN stating that he wished to consider the statistical and mathematical basis for the significant number of deaths and for the experts to identify those deaths which cause concern from those that did not raise any issues for investigation

NN indicating that there was a question as to whether it would be necessary to exhume any of the bodies. His current view was that exhumation was unlikely benefit the investigation but he wished his team of experts to confirm this point.

JZC querying whether the experts would be considering the appropriateness of the treatment. Stating that if there was no criminal basis for an investigation then, clearly, the GMC would be looking for the adequacy of the treatment regime. NN confirming that if he received evidence regarding any medical practitioner he would be obliged to disclose the material.

JZC advising that any expert report passed to the GMC prior to the conclusion of the criminal enquiries would lead to disclosure issues. JZC discussing the need to disclose evidence upon which the GMC wished to rely and, say, an IOC hearing. NN appreciated the disclosure issues and advising that he had to consider the key points of risk to patients and acting in the public interest. NN advising that he was aware of these issues and to the need to secure patient safety.

The police would then have to interview appropriate witnesses. He did, however, anticipate that, using 'due diligence', he did not anticipate the investigation taking 2-3 years as JZC had feared. NN advising that he hoped to have a clear idea about where the police investigation would be going by the end of 2003. He hoped to have completed his investigation and sought legal advice on the points. He was anxious to move as quickly as possible.

Family Solicitors

NN advising that he continued to have a good relationship with Ann Alexander of Alexander Harris who was acting for many of the families of the deceased relatives. He hoped that he would continue with such a relationship, it appeared that Ann Alexander shared the same view regarding rebuffed approached in any dealings with the media. Ann Alexander had indicated that she would not approach the media.

NN stating that he had a meeting with a family group on 5 February 2003. Alexander Harris and the other patient groups would be attending this matter which was designed as an open forum.

NN querying whether JZC would be happy for NN to mention that Hampshire Constabulary were liaising with the GMC on a regular basis and keeping them fully informed of the circumstances surrounding the investigation.

Conclusion

All parties confirming that the meeting had been useful as an updating exercise and reiterating their intention to continue to have regular meetings throughout the duration of the criminal enquiries.

Matter BACTON Date 31/01/03

Attending Michael Keegan

Telephone Call	IN	OUT	In Person	

Re arranging meeting with MK for

2pm on 05/02/03.

(Checking JMO's diary for availability)

Action to be taken

Time occupied .... Initials ....

GMC100942-0503

Attending ______________________________

Telephone Call | IN | OUT | In Person | [ ]

<u>Action to be taken</u>

Time occupied .... Initials ....

Chrystie, Judith

From: Code A
Sent: 21 January 2003 09:21
To: Chrystie, Judith
Subject: Message from Michael Keegan

Importance: High

He cannot make the meeting arranged for tomorrow as he has to attend a funeral. If you would like to talk to him about re-arranging, he is there today.

He has tried to send you an e-mail but has been told that it is queuing in the system for some reason so thought he'd better call.

Code A
Sec. to Kathy Tormann/Kate Smith/Judith Chrystie/Aidan McManus
Professional Regulatory Group
Code A

Chrystie, Judith

From: Michael Keegan (7915 7437) Code A
Sent: 20 January 2003 12:08
To: Judith Chrystie (E-mail)
Subject: Dr Barton

Dear Judith,

I am sorry to have to cancel our meeting planned for Wednesday. I must attend a funeral in Lincolnshire and will be away all day Wednesday and Thursday.

I am free for the rest of January, excluding 27, 28 and 31, and for all of the early part of February. Please let me know when you have an alternative gap in your diary and I will do my best to attend.

Apologies for any inconvenience casued to either you or John..

Michael

Michael Keegan
Conduct Case Presentation Section
Code A

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Notification of Receipt of Contact

Date: 30 January 2003 Your Ref: 586

Dear Ms. Judith. Chrystie

Thank you for your letter/~~email/telephone call~~ of 29 January 2003 received at the Commission for Health Improvement on 30 January 2003 If appropriate, you will receive a response within 20 working days.

Yours sincerely

RECEIVED
31 JAN 2003

Investigations Department
11th Floor

GENERAL
MEDICAL
COUNCIL

Protecting patients,
guiding doctors

RECEIVED
17 [illegible] 2003

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 reference: FR/PR/31243/1/9516
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

15 January 2003

Mr Richard Follis

Code A

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letter of 15 January 2003.

This is an information case because we were first alerted to these matters by the Hampshire Constabulary in July 2000. This followed allegations made to them by the family of Gladys Richards.

We subsequently received correspondence from Mrs Jackson, Mr Page, Mr Wilson, Mrs Carby, Mr Farthing and Mrs McKenzie between April and June 2002. As advised in our letter dated 21 November 2001, we responded to each setting out our powers and procedures and that we were considering a case against Dr Barton in light of the information received from the Hampshire Constabulary.

As you know, we are still considering whether to include the case of Stanley Carby under No. 11 of the GMC PPC and PCC (Procedure) Rules 1988; I should be grateful if you would let Mrs Carby know that, with Police inquiries ongoing and our investigations thereby stayed, we are unable to reach a decision on that question at the moment.

It may be of interest to note that, in complainant cases, we no longer fund complainants' choice of solicitors. I trust that clarifies the situation and that both you and your clients will continue to assist Messrs Field Fisher Waterhouse in the preparation of this case for hearing.

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

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

c.c. Ms J Christie, Field Fisher Waterhouse

5a

Alexander Harris
solicitors

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

Our ref: RF/EP/31243/1/9516
Your ref: MK2000/2047
Please ask for: RICHARD FOLLIS
Direct dial: Code A

15 January 2003

ALSO BY FAX 020 7915 3641

Dear Mr Keegan

Re: Gosport War Memorial Hospital

I thank you for your letter of 18th December received shortly before the Christmas break.

I have to confess to some puzzlement as to how it is that this case proceeds as an information case, as opposed to a complainant case, given that the impetus has come, so far as I am aware, entirely from the complaining relatives.

Upon what information are the GMC proceeding?

When and why was the matter determined to be an information as opposed to a complainant case and by whom?

There are a series of complainants who by reason of your categorisation are deprived of the right to be represented by their solicitor of choice. Your further observations would be appreciated.

Yours sincerely

Code A

RICHARD FOLLIS
PARTNER
ALEXANDER HARRIS

Code A

Alexander Harris, Chorlton House, 61 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100
DX 720080 Solihull. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 925 5555 Facsimile: +44(0)161 925 5500 DX 19866 Altrincham 1.
1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.

Partners: David N Harris LL.B, Ann Alexander LL.B (Hons) M.B.A (Managing Partner), Lesley Herbertson M.A (Cantab), Nicola Castle LL.B (Hons) LLM, Richard Follis LL.B (Hons), Jenny Kennedy, Lindsay Wise B.A (Hons), Grainne Barton LL.B (Hons), Richard Barr, Christian Beadnall LL.B (Hons), Auriana Griffiths LL.B (Hons)
Consultants: Robin Houghton LL.B (Hons), Prof. Daniel S Simons B.A (Hons) J.D (Member of the Florida Bar)
Associates: Yee Fon Sit LL.B (Hons), Douglas I. Silsy LL.B (Hons), Susannah Road LL.B (Hons), Tim Annett LL.B (Hons), Kim Barnett B.A (Hons) LLM, Jonathan Betts LL.B (Hons), Jo Maskam LL.B (Hons), Chris Binns LL.B (Hons), *Sue Taylor, *Debbie Murphy RGN, RM, Dip N, *Kirsty B Richards, *Kirsten Lamb B.Sc (Hons). *(not a practising solicitor)

Alexander Harris is a franchised firm and a member of the Community Legal Service
Regulated by The Law Society

Chrystie, Judith

From: Chrystie, Judith
Sent: 16 January 2003 13:46
To: 'Michael Keegan [Code A]'
Subject: RE: Dr Barton

Dear Michael

Many thanks for your email. Sorry for the delay in responding: I have been over at CHI.

I will update you next week as to the documents and information CHI held and any information DI Niven passes to me on Tuesday. I will also ask him to make a formal request to us for the release of papers (I suggest that the request is comprehensive to include all the papers we hold - even those that you are content to release now - for the sake of consistency).

See you at 2pm on Wednesday!

Kind regards
Judith

-----Original Message-----
From: Michael Keegan (7915 7437) [mailto: Code A
Sent: Wednesday, January 15, 2003 4:39 PM
To: Judith Chrystie (E-mail)
Subject: Dr Barton

Dear Judith,

I have had a chance to speak about disclosure to the Police of the IOC transcript in this case and consequently advise that the Police should make a formal, reasoned request for the same. That request can then be considered at a senior level. This is, as you can imagine, in light of both the sensitivity of this case and the lack of precedent of which we are aware.

I should be grateful if you would communicate this to DI Niven.

Regards

Michael Keegan
Conduct Case Presentation Section
Direct
Direct
Email: Code A

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Matter BACON Date 16/01/03

Attending Nigel Nixon

Telephone Call | IN | OUT | In Person

Call from DR Nixon

GMO – meeting – last Monday.

All other people in NHS have been asked to stand down.

GMC
Whose position in writing – helpful

Arranging to meet 10-10.30 on 21/01

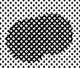
JLC to fill in on CM1

NN to update

Action to be taken

Parties to discuss minutes

Time occupied .... Initials ....



Matter BARTON Date 10/01/03

Attending Vincent Kilbane - Julie Miles, GMC

Telephone Call	IN	OUT	In Person	

Julie phoning in connection with ICC's letter.

Copies of the public documents requested in November by by ICC would be available next week.

She looked forward to meeting with ICC and JMO next week.

TE - 1 unit

Action to be taken

Time occupied .... Initials ....

RECEIVED
09 JAN 2003

Your reference: JZC/HJA/00492-14742/2145525v1
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

7 January, 2003

Ms Judith Chrytie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

Dr Jane Barton

At Ian Barker's request I have written to him to confirm that the provisional date for the Professional Conduct Committee, namely 7 April 2003, will not now be used, owing to the ongoing police inquiries. He has stood down counsel accordingly.

I have still not received the attendance notes of the meetings on 3 October or 20 November 2002. I also await confirmation of the time of our meeting scheduled for 22 January; may I suggest 14:00? I am happy to attend your offices.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct l
Direct f
Email: Code A

Chrystie, Judith

From: Chrystie, Judith
Sent: 08 January 2003 20:27
To: 'Niven, Nigel'
Subject: RE: Minutes

Docs_2137965_2.DOC

Dear Nigel

Many apologies for the delay in responding. I have been out of the office until today.

I attach the draft minutes for your attention. Would it be possible to 'track' your changes so that I can identify the amendments and additions that you have made.

Many thanks and happy New Year.

Kind regards
Judith

-----Original Message-----
From: Niven, Nigel [Code A]
Sent: Tuesday, December 31, 2002 11:54 AM
To: Chrystie, Judith
Subject: Minutes

Judith,

Thanks for the draft of the notes. We do have a number of clarifcations to do. Can you email me down a copy so I can make the changes. If this can not be done I will get them re-typed at this end to include our thoughts and send them to you.

Have a good New Year.

Best wishes

Nigel

.***
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****

Matter BAYCAN Date 08/01/03

Attending Kelly Child, CHI

Telephone Call | IN | OUT | In Person | |

Call to Kelly returning call

Confirming JLC and IMO's attendance at CHI's offices

on Tuesday/Wednesday next week.

Indicating JLC anticipated needing 2 days

Kelly advising there was no difficulty at her end

JLC to confirm in writing

Action to be taken

Code A

Time occupied .... Initials ....

Code A

FIELD FISHER WATERHOUSE

fax

To:	Ms J Miller	Fax:	020 7448 9222
At:	Commission for Health Improvement	Pages including this one:	
From:	Judith Chrystie	Date:	9 January 2003
Our ref:	JZC/HJA/00492-14742/2180223 v1	Your ref:	

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General Medical Council - Dr. J Barton

Please see attached

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 **Fax** +44 (0)20 7488 0084 **e-mail** info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com **CDE** 823

London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Leipzig Munich Paris

Regulated by the Law Society. A list of the names of the partners of FFW and their professional qualifications is open to inspection at the above office.
The partners are either solicitors or registered foreign lawyers.
The European Legal Alliance is an alliance of independent law firms

FIELD FISHER WATERHOUSE

Our ref: JZC/HJA/00492-14742/2180723v1

Strictly Private & Confidential

Ms J Miller
Commission for Health Improvement
Finsbury Tower
103-105 Bunhill Road
London EC1Y 8TG

9 January 2003

Dear Ms Miller

General Medical Council - Dr. J Barton

I refer to my letter dated 28 November 2002 and to our conversation on 4 December 2002.

During that conversation you indicated that you were happy to supply the documents listed in the schedule accompanying my correspondence but wished to check the position with the Trust before passing copies to me. Please could you indicate when you hope copies of the documents may be available for our consideration?

In addition, I write to confirm that I, and my colleague, John Offord, will attend at your offices on 14 and 15 January 2003 in order to examine the statements and other relevant documents you hold in relation to the CHI investigation into Gosport War Memorial Hospital. John and I look forward to meeting with you at 10.30am.

Please do not hesitate to contact me on the direct dial number below should you wish to discuss any matter in advance of our meeting.

Yours sincerely

Code A

pp Judith Chrystie

Direct
Email: Code A 3

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823
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FIELD FISHER WATERHOUSE

Our ref: JZC/HJA/00492-14742/2180712 v1
Your ref: MK/2000/2047

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

9 January 2003

Dear Michael

Dr. Jane Barton

I refer to the above matter.

Since my letter through to you dated 17 December 2002 I have attempted to forward the missing enclosures through e-mail. Each time I have done so a few days later I receive an indication that the documents have not been received with you! My last effort was on 24 December 2003 and I returned to the office yesterday – my first day back in the office since the Christmas break – to find another rejection advice.

I have checked the e-mail carefully and am using the following address: **Code A** I wonder if the documentation I am supplying occupies too much 'space' to be allowed through the GMC's firewalls. As technology has failed me, I enclose hard copy versions and apologise for the earlier omission.

As I indicated, a copy has been forwarded through to Detective Inspector Nigel Niven. Nigel has indicated that they wish to clarify certain aspects of the note. I await his amendments for inclusion in the note and for discussion with you.

As you are aware, John and I are scheduled to attend at the offices of CHI next week and we shall update you at our meeting on 22 January 2003. Would a time of 2.00pm be suitable for you? Unless I hear from you to the contrary, I look forward to meeting with you again then at our offices.

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel [illegible] Fax [illegible] e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823
London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

In your letter dated 18 December 2002 you request my thoughts on the inclusion of Mr Carby's complaint under a Rule 11(2) referral. I thought that I had addressed this issue with you at our pre-meeting on 20 November 2002 at which I indicated that the other matters received by the GMC did appear appropriate to be considered under Rule 11(2).

I do not, however, consider that it would be appropriate for us to undertake any investigation at the moment as this may prejudice the enquiries being undertaken by Hampshire Constabulary. To determine definitively whether the complaint should go through to the PCC (if, indeed, we end up following a charge of serious professional misconduct as opposed to a criminal conviction), further enquiries will need to be undertaken and expert evidence obtained to determine the exact validity of the complaint.

One of the issues mentioned at our meeting in November was whether the police should receive all documentation the GMC hold in relation to this matter. My initial advice to you was that it would be appropriate for the material, in particular the documents considered by the PPC, the letters received on behalf of Dr. Barton, the transcript of the IOC hearing and the additional papers received regarding the incident in 1991 to be disclosed. I confirm this advice. Within the Medical Act 1983 (as amended) the GMC made disclose "*to any person any information relating to a practitioner's professional conduct, professional performance or fitness to practise which they consider it to be in the public interest to disclose*" (Section 35B).

Are you content that it is in the public interest to disclose the material I have identified above? Should you confirm that the GMC consider it to be in the public interest, I shall pass the relevant documentation through to Detective Inspector Niven.

I hope that you had a restful Christmas and New Year break and that the move into your new home went smoothly.

See you next week!

Kind regards,

Yours sincerely

Code A

pp Judith Chrystie

Code A

Chrystie, Judith

From: Chrystie, Judith
Sent: 24 December 2002 13:57
To: Code A
Subject: FW: Barton - missing notes

I shall try to get these through to you again! The GMC would not accept them yesterday!

Judith

-----Original Message-----
From: Chrystie, Judith
Sent: Monday, December 23, 2002 8:49 AM
To: Code A
Subject: Barton - missing notes

Dear Michael

I attach the attendance notes omitted from my letter through to you last week! Apologies!

Merry Christmas!

Kind regards
Judith

Judith Chrystie

Code A

Chrystie, Judith

From: Chrystie, Judith
Sent: 23 December 2002 08:49
To: Code A
Subject: Barton - missing notes

Dear Michael

I attach the attendance notes omitted from my letter through to you last week! Apologies!

Merry Christmas!

Kind regards
Judith

Judith Chrystie

Code A

FIELD FISHER WATERHOUSE

Our ref: JZC/HJA/00492-14742/2147222 v1

Strictly Private & Confidential

D.I. N Niven
Major Crime Investigations Team
Hampshire Constabulary
Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire SO15 2JS

23 December 2002

Dear Nigel

General Medical Council - Dr. Jane Barton
Operation Rochester – Gosport War Memorial Hospital

Thank you for your letter dated 2 December 2002 providing an update and formally requesting that the GMC's disciplinary proceedings are stayed pending the outcome of the police investigation and enquiries.

I have received formal instructions from the GMC to confirm that the GMC proceedings regarding Dr Barton's fitness to practise will be stayed pending the conclusion of the police enquiry.

I look forward to liaising with you in the future.

Code A

Judith Chrystie

Code A

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823

London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

FIELD FISHER WATERHOUSE

Our Ref: JZC/00492-14742/2164803 v1

Strictly Private & Confidential

D.I. N Niven
Major Crime Investigations Team
Hampshire Constabulary
Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire SO15 2JS

23 December 2002

Second letter

Dear Nigel

General Medical Council - Dr. Jane Barton
Operation Rochester – Gosport War Memorial Hospital

I write separately to my formal letter confirming the GMC's formal instructions to me that disciplinary proceedings will be stayed.

I enclose a copy of the meeting note I made following our productive meeting on 20 November 2002. Should you have any changes you wish incorporate into the note please do not hesitate to contact me following which I shall make the amendments and forward an updated set of minutes to you.

In accordance with your agreement, I confirm that John Offord and I have arranged to review the documentation held by the Commission for Health Improvement on 14-15 January 2003. During our visit we shall analyse the material held by CHI but we do not propose to take any action on it other than requesting copies of relevant material and assessing whether, following the conclusion of the police enquiries, whom of the witnesses interviewed by CHI should be seen by this firm.

Finally, many thanks for your Christmas card – absolutely magnificent!

Code A

Judith Chrystie
Assistant Solicitor

Code A

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823
London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

Chrystie, Judith

From: Lohn, Matthew
Sent: 23 December 2002 18:55
To: Chrystie, Judith
Subject: RE: Barton

the GMC have a discretion under S35A of the Medical Act to disclose in the public interest - it would seem reasonable to exercise such a power in these circumstances but the decision must be made by the GMC not us

-----Original Message-----
From: Chrystie, Judith
Sent: Monday, December 23, 2002 8:46 AM
To: Lohn, Matthew
Subject: Barton

Do you foresee any difficulty supplying Hampshire Constabulary with the following:

1 Papers considered by the PPC together with Jane Barton's response to the Rule 6 letter
2 Details a new complaints received by the GMC
3 Transcript of IOC hearing.

Would presume that this would all be permissible under s35 of DPA....

Thanks!
Judith

Judith Chrystie
Professional Regulatory Group
Code A

GMC100942-0528

GENERAL
MEDICAL
COUNCIL
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guiding doctors

Your reference: JZC/HJA/00492-14742/2145525v1
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

18 December 2002

Ms Judith Chrytie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

Dr Jane Barton

Thank you for your letter of 17 December 2002. Unfortunately neither of the attendance notes of the meetings on 3 October or 20 November were enclosed. I acknowledge receipt of the copy letter dated 2 December from DI Nigel Niven.

As discussed, I can instruct you to agree DI Niven's request that we stay proceedings pending the outcome of the criminal investigation. I am also happy to agree to your visit to CHI on 14-15 January and the adjournment of our meeting to 22 January 2003, when I am free all day. I am happy to attend at your offices if you would like to confirm a time.

I should be grateful for your thoughts on the inclusion of Mrs Carby's complaint concerning her late husband, Stanley, under Rule 11.

May I take this opportunity to wish both John and you a merry Christmas and happy New Year.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line/Direct Fax: Code A
Email: Code A

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GMC100942-0529

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Your reference:	FR/PR/31243/1/9516	
In reply please quote	MK/2000/2047	

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

18 December 2002

Mr Richard Follis
Alexander Harris
Cheriton House
51 Station Road
Solihull
West Midlands B19 3RT

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letters of 12 and 13 December 2002.

I acknowledge receipt of Mr Farthing's authority and that your clients wish for you to deal with the preparation of the cases for hearing and the presentation/advocacy at the hearing.

This is an information case, as opposed to a complainant case; the relatives are not parties to the proceedings in the meaning given in paragraph 13 of Schedule 4 to the Medical Act 1983. We have, as you know, instructed Field Fisher Waterhouse to prepare this case for presentation for hearing by the Professional Conduct Committee and I trust that you and your clients will assist them with any further work necessary to prepare this matter.

We cannot, as you know, proceed to public inquiry while police investigations are ongoing. I am advised that those investigations are not likely to be concluded in the immediate future. It does not appear, therefore, that the PCC will be able to consider this case in the early part of next year, as we had hoped. We will, of course, advise you of developments at each stage, as appropriate.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax: Code A
Email: Code A

c.c. Ms J Christie, Field Fisher Waterhouse

FIELD FISHER WATERHOUSE

attendance note

Name: **Judith Chrystie**	Call type: **Telephone call**
Att:	From:
Duration:	Date: **17 December 2002**

Barton

JZC telephoning Michael Keegan to return his call. JZC had attempted to send an email through to MK earlier that day but had received a notice stating that the email was undelivered.

JZC advising that the email had contained a letter through to MK providing him with an update of the case. The letter would be forwarded through to Michael by hard copy and, therefore, JZC did not propose to re-send the email.

JZC and MK discussing the matter. MK confirming that the hearing date in April would be vacated following the request by Hampshire Constabulary.

MK advising that he had recently received letters from Alexander Harris confirming that they acted for another one of the families who relative had died whilst under the care of Dr Barton. In another letter from Alexander Harris they had asked for confirmation that they would be able to carry out the investigation and the advocacy at the GMC hearing.

MK had recognised that this was an information case and, consequently, the relatives were not complainants under the Medical Act and did not have any locusts or rights in the proceedings. MK proposed to write to Alexander Harris to this effect.

JZC and MK discussing the review of the CHI documents arranged for mid-January 2003. MK agreed with JZC that it was unnecessary to bring this meeting forward owing to the fact that we were unable to investigate the matter comprehensively at this stage. MK also agreeing that the round table meeting between JZC, MK and JHO should be rescheduled for 22 January 2002.

JZC

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: JZC/HJA/00492-14742/2145525 v1
Your ref: MK/2000/2047

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

17 December 2002

Dear Michael

Dr. Jane Barton

Thank you for copies of the letters you have recently sent through to Alexander Harris.

Following our meeting with the Hampshire Constabulary on 20 November 2002 I thought it would be helpful to send you an update.

Attendance Notes

I enclose a copy of the attendance note of the meeting held on 3 October 2002. I noted, on a review of the file, that I had not forwarded the document to you earlier. You may wish to add this to your file for information.

In addition, I enclose a copy of the meeting note taken after the meeting with Hampshire Constabulary last month. I have forwarded a copy of the note to Nigel Niven together with a request that he advises me of any changes he wishes incorporated into the document. Should any amendments be made, I shall forward a further copy of the note to you.

Hampshire Constabulary

I recently received the enclosed letter from Nigel Niven which formally requests that the GMC's enquiries and proceedings are stayed pending the outcome of the criminal investigation. As Nigel suggested at the meeting, our hearing date of April 2003 should be vacated as the police investigation is likely to be lengthy; indeed it appears that following the meetings with the CPS a decision has been

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taken to enlarge the parameters of the investigation. If the expansion involves the hundreds of patients who were certified dead by Dr. Barton and treated by her during their stay at Gosport War Memorial Hospital, the investigation could take, as we were warned, some years. When I next speak with Nigel Niven on the telephone I will attempt to get some indication of the degree to which the enquiries have been enlarged.

I should be grateful if you could provide me with instructions to write to Hampshire Constabulary to advise them formally that the GMC proceedings will be stayed pending the outcome of the police investigation. Currently I have acknowledged Nigel's letter and indicated that we are seeking your formal response.

Commission for Health Improvement

At the meeting you will recall that Nigel provided with specific permission to contact CHI in order to examine their documents and the statements they had obtained during their Inquiry. The permission was granted on the basis that we would not contact any of the individuals but were merely assessing the documents and the material held by CHI.

Following the meeting and prior to my holiday last week, I wrote to Julie Miller at CHI requesting a number of documents and asking for inspection facilities in respect of the witness statements and other material held by CHI. I have received a response from Ms Miller who has indicated her willingness to cooperate with the GMC's enquiries. Unfortunately, it has not been possible to find a two-day slot in which my, John Offord's and Julie Miller's diaries are all free until 14-15 January 2003. Given, however, the fact that we will be unable to hold the hearing in April 2003, I do not consider that it is of concern that we must wait until mid-January before visiting CHI. I hoe that you agree.

In light of the fact that it has not been possible to arrange an appointment with CHI prior to the New Year, I wonder whether it would be beneficial for us to postpone the meeting tentatively arranged for 8 January 2002 to 22 January 2002. This would allow John and I to update to as to the documents and information we obtained from our visit to CHI. Are you free on this date?

I look forward to hearing from you.

Kindest regards,

Yours sincerely

Code A

Judith Chrystie

Code A

Chrystie, Judith

From: Chrystie, Judith
Sent: 06 December 2002 14:46
To: 'Niven, Nigel'
Subject: RE:

Dear Nigel

Yes, many thanks - it arrived on 04 December whilst I was out of the office. I have dictated a response and have sought formal instructions from the GMC to confirm that the action is stayed and that the hearing date in April is vacated pending the police enquiries.

I was glad to see that following your meeting with the CPS, you have been able to both continue and expand your enquiries. Good news!

Best wishes
Judith

-----Original Message-----
From: Niven, Nigel [mailto: Code A
Sent: Friday, December 06, 2002 2:07 PM
To: Chrystie, Judith
Subject:

Judith,
Did you get my letter?
Nigel

.***

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FIELD FISHER WATERHOUSE

attendance note

Name:	**JZC**	Call type:	**Telephone call (out)**
Att:	**Julie Miller**	From:	**Commission for Health Improvement (CHI)**
Duration:		Date:	**4 December 2002**

Dr. Barton

JZC telephoning Julie Miller, at the Commission for Health Improvement (CHI).

JZC introducing herself. Julie Miller had received JZC's letter and was happy to cooperate as far as possible.

JZC advising that that day she had received a formal request from Hampshire Constabulary to stay the GMC proceedings pending the conclusion of the police Inquiry. JZC stating that she had, however, received confirmation from the police that it would be appropriate for her to visit CHI in order to examine the documents. JZC stating that she did not intend to take any action other than to request copies of the documents; for example, she did not intend to contact any of the witnesses that CHI had obtained statements from during their own enquiries.

JZC stating she was anxious not to do anything to prejudice the police enquiries but she did wish to be 'ahead of the game' once the police enquiries had concluded and the GMC could continue with their own investigations.

Julie Miller stating that she was more than happy to assist. She would, as a matter of courtesy, write to the Trust in order to identify the documents that JZC had requested on her schedule. Copies would be provided within the next week or so.

In addition, Miss Miller stating that if JZC intended to contact any of the witnesses that had previously been examined by CHI, she would prefer to write through to the witnesses first to warn them that FFW may be contacting them. JZC appreciating that Miss Miller would wish to contact the witnesses and this would be a continuity of correspondence.

Miss Miller stating that a new system of collation had been used which used codified information when interviewing witnesses. Stating that there were, however, handwritten notes of the discussions with the witnesses. She would discuss the ways in which information had been recorded with JZC on the visit. JZC considering John Offord's diary and her own and agreeing with Miss Miller that JHO and herself would visit CHI on 14-15 January 2003 in order to examine the documentation.

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*** TX REPORT ***
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RESULT	OK

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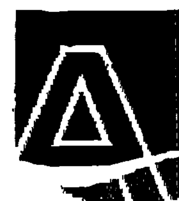

fax

To:	Ms Julie Miller	Fax:	020 7448 9222
At:	Commission for Health Improvement	Pages including this one:	7
From:	Judith Chrystie	Date:	28 November 2002
Our ref:	JZC/HJA/00492-14742/2126843 v1	Your ref:	

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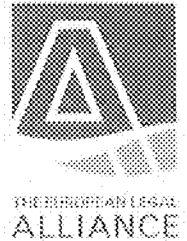
General Medical Council - Dr. Barton

Please see attached



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Our ref: JZC/HJA/00492-14742/2126843 v1

Strictly Private & Confidential

Ms Julie Miller
Commission for Health Improvement
Finsbury Tower
103 - 105 Bunhill Road
London EC1Y 8TG

28 November 2002

Dear Ms Miller

General Medical Council - Dr. J Barton

This firm is instructed on behalf of the General Medical Council in pursuing an investigation into the conduct of Dr. Jane Barton. The matter has been provisionally listed for a disciplinary hearing before the GMC's Professional Conduct Committee in April 2003.

I am the solicitor with conduct of the case. A copy of the CHI Report into the investigation at Gosport War Memorial Hospital has been forwarded to me. I am eager to analyse a number of the relevant documents and evidence amassed during your investigations and understand from the GMC that you are able to assist.

The documents I would like to examine are listed in Appendix A to the Report. I attach a schedule which identifies the documents I would appreciate analysing. Please could you arrange for copies of the documents to be forwarded to me. This firm will be responsible for your reasonable copying costs. Alternatively, you may wish to forward the documents you hold to this firm. We shall make copies immediately and return the original versions to you. Perhaps you could telephone me in order to discuss which way you would like to proceed.

In addition, I note that the investigation interviewed a number of stakeholders and staff and non-executive directors at Portsmouth Healthcare NHS Trust. I should be grateful if I, and my colleague, John Offord, could visit your offices in order to read the statements and identify those individuals who may assist the GMC Inquiry.

Field Fisher Waterhouse

London

At present, we would not intend to contact any of those individuals. We are advised that there is an ongoing police investigation and we have given assurances to Hampshire Constabulary that we will not contact witnesses or undertake any task which could prejudice their investigation. We have, however, specifically requested whether it would be possible for us to analyse your records and are advised that this would not hamper police enquiries.

In addition, we would not propose to contact any witnesses interviewed by CHI until you have had an opportunity to write to those individuals to place them on notice. Again, perhaps we could discuss this issue over the phone?

I look forward to hearing from you. I am afraid that I will, however, be out of the office on annual leave until 3 December 2002.

Thank you in advance for your cooperation.

Yours sincerely

Code A

pp Judith Chrystie

Code A

General Medical Council

Dr. Jane Barton

Schedule of Documents

	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 – 1998-1999
3.	Looking forward… the next five years 1995-2000, Portsmouth Healthcare NHS Trust 1994
4.	Business plans 1998-1999, 1997-1998, Portsmouth Healthcare NHS Trust
5.	National service framework: older people steering group (district wide implementation team) documents, Isle of Wight, Portsmouth and South East Hampshire health authority, undated
6.	Portsmouth Healthcare NHS Trust, Quality report – governance indicators, quarter ending 31 December 1998, 30 September 1998, 30 June 1998, 31 March 1998, 31 December 1997, 30 September 1997, 30 June 1997
7.	Improving quality – steps towards a First class service, Portsmouth Healthcare NHS Trust September 1998
8.	Strategy for human resource management and important human resource issues, Portsmouth Healthcare NHS Trust, personnel director, October 1996
9.	Human resource management, Portsmouth and South East Hampshire Health Authority Community Health Care Services, November 1991
10.	Clinical Stroke service guidelines, Department of medicine for elderly people, undated
11.	Reaudit evaluation of compliance with revised handling assessment guidelines, Portsmouth Healthcare NHS Trust, June 1998 – November 1998
12.	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.

13.	Referral to old age psychiatry form, Portsmouth Healthcare NHS Trust, undated
14.	Patients affairs procedure – death certification and post mortems, department of medicine for elderly people, Queen Alexandra Hospital, (undated)
15.	Audit of patient records, December 1998 – July 1998, Portsmouth Healthcare NHS Trust
16.	Audit of nutritional standards, October 1997 – April 1998, Portsmouth Healthcare NHS Trust, undated.
17.	Wessex palliative care handbook: guidelines on clinical management, fourth edition, Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, The Rowans (Portsmouth Area Hospice), undated
18.	National sentinel clinical audit, evidence based prescribing for older people: Report of national and local results, Portsmouth Healthcare NHS Trust, undated
19.	Compendium of drug therapy guidelines 1998 (for adult patients only), Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, 1998
20.	Draft protocol for prescription and administration of diamorphine by subcutaneous infusion, medical director, Portsmouth Healthcare NHS Trust, 15 December 1999
21.	Administration of controlled drugs – the checking role for support workers: guidance note for ward/clinical managers, Portsmouth Healthcare NHS Trust, February 1997
22.	Summary medicines use 1998/1998 to 2000/2001 for wards Dryad, Daedalus and Sultan, Portsmouth Hospitals NHS Trust pharmacy service, April 2002
23.	Clinical nursing development, promoting the best practice in Portsmouth Healthcare, Portsmouth Healthcare NHS Trust, January 1998
24.	Anonymised correspondence on complaints relating to Gosport War Memorial Hospital since 1998
25.	Learning from experience: action from complaints and patient based incidents, 1998 – 2001, Portsmouth Healthcare NHS Trust
26.	Risk management strategy 1998/2001, Portsmouth Healthcare NHS Trust
	Documents relating to the Department of Medicine for Elderly People at the

	Gosport War Memorial Hospital
27.	Dryad ward away day notes, Gosport War Memorial Hospital, 18 May 1998
28.	Gosport War Memorial Hospital key objectives 1998/1999, 1997/1998 and 1995/1997, Portsmouth Healthcare NHS Trust
29.	Gosport War Memorial Hospital leaflet and general information, Portsmouth Healthcare NHS Trust, undated
30.	Patient throughput data from Sultan, Dryad and Daedalus wards 1997/1998, Fareham and Gosport primary care groups, April 2002
31.	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
32.	Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
33.	Job description: clinical assistant position to the geriatric division in Gosport, Portsmouth and South East Hampshire Health Authority, April 1988
34.	Correspondence re: consultant in medicine for the elderly contract, Wessex Regional Health Authority, 28 January 1992
35.	Essential information for medical staff department of medicine for elderly people, Portsmouth Healthcare NHS Trust, undated
36.	Department of medicine for elderly people, consultant timetables August 1997 – November 2001, Portsmouth Healthcare NHS Trust
37.	Development of intermediate care and rehabilitation services within the Gosport locality, Portsmouth Healthcare NHS Trust, undated
38.	Supervision arrangement consultant timetable at Gosport War Memorial Hospital 1998 – 2001, Portsmouth Healthcare NHS Trust
39.	Vacancy levels 1998 – 2001 for Sultan, Daedalus and Dryad, Portsmouth Healthcare NHS Trust, 21 November 2001
40.	Sickness absence statistics for Sultan Ward, Gosport War Memorial Hospital, 1998 – 2001, undated

41.	Wastage for qualified nurses – Daedalus, Dryad and Sultan Ward, undated
42.	Winter escalation plans elderly medicine and community hospitals, Portsmouth Healthcare NHS Trust, undated
43.	Audit of detection of depression in elderly rehabilitation patients, January – November 1998, Portsmouth Healthcare NHS Trust, undated
44.	Community hospitals: guidelines for confirmation of death, Portsmouth Healthcare NHS Trust, policy date May 1998
45.	Competence record and development for qualified nurses 1998 – 2001, Sultan Dryad and Daedalus wards
	Other Documents Relating to Gosport War Memorial Hospital
46.	Clinical governance and clinical quality assurance, the baseline assessment framework, NHS Executive south east region, 1999
47.	Clinical governance, Audit 1998/1999 and Summary report, District Audit, December 1999

Chrystie, Judith

From: Niven, Nigel [Code A]
Sent: 05 November 2002 09:54
To: Chrystie, Judith
Subject: RE: Meeting 20/11/02

Judith,
Thanks for the below. A map would be useful if are able to Email it.
Otherwise a fax would be fine.
Many regards
nigel

-----Original Message-----
From: Chrystie, Judith [mailto: Code A]
Sent: 05 November 2002 09:21
To: Niven, Nigel
Subject: RE: Meeting 20/11/02

Dear Nigel

Thank you for your email.

I confirm that I have booked a room in our offices from 11.30-2.30 on 20
November 2002 and have ordered a sandwich lunch to keep us going!

Please let me know if you would you like a map showing the location of
our
offices.

I look forward to meeting with you then.

Best wishes
Judith

Judith Chrystie
Professional Regulatory Group
Code A

-----Original Message-----
From: Niven, Nigel [Code A]
Sent: Monday, November 04, 2002 12:52 PM
To: Code A
Subject: Meeting 20/11/02

Ms Chrystie.

Dear Judith,

Further our telephone conversation last week re our meeting. I wonder
how
1130 fits with your schedule on the 20/11/02. I no longer have to go to
NSY
so we can have as long as we need. I will be accompanied by DS Owen
Kenny.
If this is all OK with you, can you either Email me or give me call on
Code A

Thanks

Nigel

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SUBADDRESS
CONNECTION ID
ST. TIME            29/11 12:00
USAGE T             01'59
PGS. SENT             7
RESULT              OK
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FIELD FISHER WATERHOUSE

fax

To:	Ms Julie Miller	Fax:	Code A
At:	Commission for Health Improvement	Pages including this one:	7
From:	Judith Chrystie	Date:	28 November 2002
Our ref:	JZC/HJA/00492-14742/2126843 v1	Your ref:	

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General Medical Council - Dr. Barton

Please see attached

FIELD FISHER WATERHOUSE

fax

To:	**Ms Julie Miller**	Fax:	**020 7448 9222**
At:	**Commission for Health Improvement**	Pages including this one:	7
From:	**Judith Chrystie**	Date:	**28 November 2002**
Our ref:	**JZC/HJA/00492-14742/2126843 v1**	Your ref:	

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General Medical Council - Dr. Barton

Please see attached

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Chrystie, Judith

From: Vodden, Jo
Sent: 13 November 2002 10:09
To: Chrystie, Judith
Subject: RE: GMC Press Search 4/11/02 -11/11/02

8 of 42 DOCUMENTS

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UK Newsquest Regional Press - This is Hampshire

November 10, 2002

SECTION: News

LENGTH: 396 words

HEADLINE: Inquiry demanded into hospital deaths.

BYLINE: Sian Davies (author email sian.davies@soton-echo.co.uk)

DATELINE: FAREHAMANDGOSPORT

BODY:

FAMILIES of elderly patients who died while at Gosport War Memorial Hospital are calling for a public inquiry into their deaths.

At a press conference staged by a legal firm which is representing 27 families, solicitor Ann Alexander confirmed they would be pressing for a full and thorough investigation.

She said: "We would not rule out calling for an inquiry from any agency but I understand the police are currently reinvestigating complaints and I will be meeting with them later this week."

At the press conference held this morning it was also revealed that 30 more concerned relatives have complained to Hampshire police regarding the care their loved ones received while recuperating at the cottage hospital during the late 1990s.

In a statement read by Richard Follis of Alexander Harris, the legal firm that also represented the families of victims of mass murderer Harold Shipman, criticism was voiced on a lack of co-ordination between the police and other agencies during previous investigations.

He said: "Numerous relatives had made complaints to police, the **General Medical Council,** the Nursing and Midwifery Council, the hospital trust and the health authority.

In several cases early complaints to the police had met with little or no satisfactory response.

"The family hope that a proper investigation and inquiry would at last be undertaken to look into numerous concerns expressed and that where appropriate there would be accountability for any individual or system failure that might have occurred."

At a meeting of the action group yesterday evening support was given for a consolidated investigation which could lead to a public inquiry, a move relatives are already backing.

Bernard Page, whose mother Eva Page died while being treated at Gosport War Memorial Hospital in 1998, said: "We want a full inquiry into this similar to the Harold Shipman case. Not behind closed doors but out in the open so that everyone is accountable. We are pleased that we have now formed the action group and are being properly represented."

The group was formed two months ago after a report by the Commission for Health Improvement criticised the prescribing of high doses of strong pain killers to elderly patients. The report also

HAMPSHIRE CONSTABULARY

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

Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

RECEIVED
-4 DEC 2002

Our Ref. Operation Rochester

Your Ref.

Code A

2nd December 2002

Judith Chrystie
Field Fisher Waterhouse
35 Vine Street
London
EC3N 2AA

Dear Judith

Re Operation Rochester – Gosport War Memorial Hospital.

You will recall that on the 20th November 2002 DS Kenny and I met with you at your offices in Vine Street. At that time I was able to provide you with a background of our investigation into certain deaths that had occurred at the above hospital.

You indicated to us that the General Medical Council were conducting an enquiry in respect of the professional conduct of Dr Jane Barton and that you anticipated that a hearing may take place in April 2003 in respect of potential misconduct allegations. You further indicated that in the event of the police conducting a criminal investigation into the same circumstances, that those proceedings could be pended until the outcome of the police investigation was known.

I was able to inform you that our investigation was ongoing and likely to take some duration and certainly not be concluded before April 2003. I also indicated that the police were due to have a meeting with the Crown Prosecution Service on the 28th November 2002 and that the extent of the police investigation would not be clear until after that meeting.

I am now able to tell you that the arranged meeting with the CPS took place. It was agreed on the basis of what was discussed to continue and expand the investigation. I have been asked by the Senior Investigating Officer, Detective Chief Superintendent Steve Watts, to notify you of this fact and to formally ask you to consider pending the anticipated hearing in April until further notice.

Within the usual accepted restraints, I will undertake to keep you appraised of developments. Whereas our roles within this matter are quite clearly and quite rightly different, it can only be in the interest of justice and the public that we continue to liaise wherever appropriate.

If I can assist you any further, please do not hesitate to contact me.

Yours sincerely

Code A

Nigel Niven
Detective Inspector 7445
Major Crime Investigation Team

FIELD FISHER WATERHOUSE

Meeting note

Name: Judith Chrystie	Call type: Meeting
Duration:	Date: 20 November 2002

Barton - Meeting with Hampshire Constabulary

Attendees:

GMC:	Michael Keegan - MK
FFW:	Judith Chrystie - JZC John Offord - JHO
Police:	DI Nigel Niven - NN DC Owen Kenny - OK

Meeting

The attendees agreeing that JZC would make a brief minuted note of the meeting for circulation to all parties.

The parties introducing themselves and explaining their involvement in the case.

JZC explaining the situation within the GMC. Advising that the GMC would not proceed if NN indicated that to do so could prejudice any policy enquiry. JZC explaining the difference between running the case as a conviction matter and one in which we had to prove serious professional misconduct. JZC indicating the criminal rules of evidence were applied in GMC proceedings.

MK updating NN and OK as to the current position of the GMC enquiries. Indicating that the matter had both been screened and placed through the PPC.

JZC clarifying that the papers that the screener and the PPC had seen had been provided by Acting Detective Superintendent Burt. Noting that these papers had been forwarded through to the GMC when it appeared that the police were no longer pursuing any criminal investigation. NN advising that when, in 1998/1999 concern was raised by the death of Gladys Richards, an investigation had taken place which the police admitted was not as effective as it should have been. Advising that the CPS had considered the investigation and, in particular, the report prepared by Livesley on the Richard's case and had taken the view that causation could not be made out.

NN explaining that following the CPS's conclusion, the families of the elderly patients stated that they considered the police had been too quick to conclude the matter and that as a consequence four other cases were "dip sampled" by a new investigating officer, Detective Superintendent James. Those other cases were considered by two alternative experts Ford and Munday.

NN indicating that he was concerned about the issue of causation and whether proving causation may be just outside of the Constabulary's reach. Noting, however, that although the file had been prepared again for the CPS (by DI Stickler) and contained information on all five cases, there were a number of other incidents which still required full investigation. NN indicating that on statistical analysis and a similar fact basis it may be possible to establish causation. Noting that there were significant arguments about the appropriateness of the prescribing regime and the instructions left by clinical staff. The attendees noting that this was a particular issue for professional regulation given that it was not necessary to show that causation resulted in death merely of the inappropriateness of the prescribing regime amounted to bad practice.

NN advising that there were 50 other cases that the police may consider. One of the issues that would have to be resolved was whether a policy decision should be made to look at the hundreds of individuals who had died at the Gosport War Memorial Hospital. Noting that from 1994 to the period in which Dr Barton resigned from the hospital, there were thousands of deaths, 600 of which had been certified by Dr Barton. There were further cases in which Dr Barton had provided the care although the death may have been certified by a different practitioner.

Given the number of cases and the provisional views being provided by an alternative expert instructed by NN, Professor Robert Forest, NN stating that he was increasingly moving towards the view that he was entitled to argue that causation could be made out. NN noting, however, the difficulty in showing that death through bronchial illness of pneumonia was a consequence of diamorphine. Although it was noted that excessive diamorphine could cause respiratory difficulties, the victims were elderly patients who were, therefore, vulnerable in any event.

NN commenting that although there was a theme developing through the cases to suggest that Jane Barton had relied on diamorphine and syringe drivers, the police had to investigate the practices of the other practitioners working at Gosport Hospital. The attendees agreed that Jane Barton could not be seen to be persecuted alone.

JZC noting that the environment in which Dr Barton was working in which there were no prescribing policies may have allowed her to operate undetected.

OK identifying the fact that in 1991 concerns had been raised regarding the use of diamorphine by junior nurses. MK and JZC advising OK that these papers had been provided to the GMC but did not take the matter further in terms of the interim procedures. OK advising the circumstances in which the concerns had been made by the junior nurses and the fact that the medical practitioners and senior nurses had been opposed to any questioning of the clinical decision making. Noting that the fact that concerns had been raised some years previously did suggest that there was something amiss with James Barton's practice over a period of years.

NN noting that there appeared to be a lack of motive. OK was continuing to look at this element.

NN advising that Liam Donaldson had asked Professor Baker to consider the issues raised by the cases identified by the police. NN had persuaded Professor Baker to also expand his enquiries into Dr Barton's GP practice. NN noting that Professor Baker's analysis of the statistics would take some time.

JZC advising that the GMC had the power to make an interim order suspending or placing conditions upon a medical practitioner's registration notwithstanding the fact that he or she had not been found guilty of serious professional misconduct. Stating that in this instance the IOC had determined not to place any interim order upon Dr Barton's registration. Noting that this was based on a convincing argument by Dr Barton explaining the lack of resources and supervision and the poor conditions under which she had had to work. Stating that given that the police were suggesting that there was potentially hundreds of deaths caused by Dr Barton and were actively assessing whether a murder charge could be prosecuted, JZC would be concerned to protect the patients and the public interest by presenting new evidence to an IOC Panel.

The parties discussing the disclosure requirements for GMC. Noting that the GMC would be forced to disclose any document which they wished to present to an IOC hearing in reliance of a request for an interim order.

NN appreciating the vulnerability of the GMC to criticism if a patient was killed at the hands of Dr Barton when the GMC could have taken action to prevent her from practising. He was, however, concerned regarding disclosure of material which he would not wish revealed to the doctor at too early a stage. NN stating that it would possible for him to write a letter for the GMC indicating that police investigations were continuing and that there were a minimum of 50 patients whose deaths would be analysed. The letter could also advise that early medical advice suggested that the deaths had been hastened by the prescribing regime provided by Dr Barton. The attendees agreeing that the letter from NN would also formally request that the GMC state their proceedings.

JZC expressing concern that the defence could argue that Dr Barton was no longer working at Gosport War Memorial Hospital and, therefore, patients were not at risk from diamorphine prescriptions or syringe drivers. OK noting in this regard that Dr Barton's private practice would include elderly patients. JZC commenting that although she appreciated that it had not yet been determined whether the criminal enquiry should consider the private/GP practice, it would be helpful if the fact that investigations may be expanded in this direction could be included within the letter to the GMC. NN stating that whilst he would wish to assist the GMC as far as possible, it may be

difficult for him to add this element to any letter. Noting that Professor Baker had agreed to expand his analysis to include Barton's private practise, but this was not part of his specific remit established by Liam Donaldson.

NN advising that the letter to the GMC would also formally establish the Constabulary's commitment to liaise closely with the GMC. The parties agreeing that formal letters would be written outlining information that was possible for the GMC to disclose. There would also be contact through e-mail, telephone and further meetings. JZC advising that she was likely to phone NN on a monthly basis so that she could report back to the GMC in her monthly reports!

The parties noting that Alexander Harris had expressed concern that the individuals involved in the various investigations and enquiries were not liaising. Noting the commitment to liaise closely could be articulated to Ann Alexander at Alexander Harris - it would, however, be necessary to stress the different role that each of the particular stakeholders were bound to adopt. Detail would not be provided about the level of communication or the information being passed between the parties but Alexander Harris should be advised that formal channels of communication had been developed.

In this regard, NN advising that he had met with Ann Alexander last week. The meeting had been productive in that it had been on a non-adversarial basis. Stating that Ann Alexander had used the media to generate publicity for her firm following the meeting, however, formal channels of communication had been established and it had been agreed that the family could raise concerns regarding any police investigation through Alexander Harris. Hampshire Constabulary had also agreed to advise any new individuals that Alexander Harris were acting for relatives; NN stressing that this would not be a referral service but merely informative.

NN stating that an important date was his meeting with the CPS scheduled for 28 November 2002. This meeting would establish the Constabulary's expectations as to the speed with which the CPS should consider the papers. NN advising that if the CPS did not consider the matter should proceed to a prosecution, the case could be considered by Treasury Counsel (an alternative Treasury Counsel from that which considered the initial referral of the Richard's case).

OK querying whether the GMC had any record of Dr Barton's qualifications as he did not have a full history or CV. The GMC would attempt to track down as much information as possible.

The GMC also would pass on any Rule 6 response letter if appropriate. JZC also advising that the GMC had received two other complaints Carby and Batson. NN and OK did not recognise these names as individuals within the 50 cases being investigated by the Constabulary. JZC to pass the documents through to the Constabulary.

There appeared to be a culture of resorting to diamorphine care too quickly (perhaps for a easy life?). The parties identified the fact that there may be problems with other doctors. MK advising NN and OK that the case against Lord had been "screened" within the GMC procedures and a decision taken not to pursue the matter.

As regards disclosure, JZC stating that she would work on the assumption that any documents provided by the police would be undisclosable unless she was specifically advised otherwise in writing. JZC stating that the GMC enquiry, once it was permitted to proceed would, of course, have to disclose any documentation passed through by the police. NN and OK appreciating this fact and noting that at that stage, in any event, the policy enquiry would be concluded. NN stating that once the police enquiry was concluded it would be possible to pass JZC all relevant documentation and, indeed, this was the basis on which the police worked.

JZC explaining that we had received a report from CHI. She explained that we wished to obtain the documents that had been considered by the CHI investigation team and, moreover, visit CHI in order to analyse the witness statements taken. Stating that there would be no intention to interview the witnesses. NN agreeing that this would not prejudice any police investigation and JZC and JHO could proceed with this aspect of the GMC enquiry.

The parties summarising the fact that NN would provide a letter to the GMC which could be used by the GMC in an IOC hearing, which would formally ask the GMC to stay their investigations and which would state that the parties were committed to regular liaison. (JZC and MK noting that it may be difficult to persuade an IOC panel to place an interim order based only on a letter but identifying that this was the best position). NN advising that the police would advise the GMC of any significant event and would release information if it was appropriate for them to do so.

FIELD FISHER WATERHOUSE

Meeting note

Name: **Judith Chrystie**	Call type: **Meeting**
Duration:	Date: **20 November 2002**

Barton - Pre-Meeting with FFW and GMC

JZC and JHO meeting with MK prior to the meeting with the Hampshire Constabulary.

JZC advising MK that this meeting was important to determine how FFW and the GMC could proceed with their enquiry. JZC advising that, to date, she had been reluctant to do anything other than read into the file owing to the possibility that action could prejudice the police enquiry.

JZC advising that she had identified the Chi documents she wished to obtain and, indeed, felt that it would be beneficial for her and JHO to go through to Chi and read the witness statements in order to identify who from the many statements taken should be proofed as part of the GMC enquiry. MK agreeing this would be useful providing the police permitted JZC to undertake this task.

MK advising that he had received a further letter from Alexander Harris (Solicitors for the relatives of the deceased elderly patients). Alexander Harris were concerned that the GMC should not proceed to a public hearing until the conclusion of the police matters. MK recognising the advice from JZC and JHO that we would be unable to do anything if the police were investigating the matter further.

JZC also stating that she and MSL had briefly considered the further complaints. Stating that these appeared to be of similar kind enough allegations to allow the matters to be presented under Rule 11(2). Stating that we would, of course, have to identify the matters to the police and to offer them the opportunity to investigate the cases.

GENERAL
MEDICAL
COUNCIL

Protecting patients, guiding doctors

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 reference: FR/PR/31243/1/9516
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

2 December 2002

Mr Richard Follis
Alexander Harris
Cheriton House
51 Station Road
Solihull
West Midlands B19 3RT

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letter of 28 November 2002.

I note the authorities enclosed with your letter and that you are awaiting one further authority, presumably from Mr Farthing.

I will certainly keep you informed of developments. You should know that we have instructed Messrs Field Fisher Waterhouse in this matter and that I have copied your letter to their Ms Judith Christie.

I spoke to a number of your clients about two weeks ago and assured them that we would not proceed to public inquiry while police investigations were ongoing. We are in ongoing liaison with the police and await further information as to the likely course of their inquiries.

As you know, we decided that no further action by the GMC was warranted in relation to Mrs Bulbeck's complaint. We are considering inclusion of Mrs Carby's complaint under No. 11 of the GMC Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988. I will revert to you about this as soon as possible.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line Code A
Direct Fax
Email: 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

5a

Alexander Harris
solicitors

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

Our ref: RF/EP/31243/1/9516
Your ref: 2002/0553
Please ask for: RICHARD FOLLIS
Direct dial: Code A

6 November 2002

Dear Mr Hudspith

Re: Gosport War Memorial Hospital

I thank you for your letter of 31st October 2002.

This firm acts for the individuals named in the attached Schedule and I would be grateful if you would please provide the information requested in my letter of 25th October in relation to each of these other complaints.

Yours sincerely

Code A

RICHARD FOLLIS
PARTNER
ALEXANDER HARRIS

richard.follis@alexanderharris.co.uk

Alexander Harris, Cheriton House, 51 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100
DX 720080 Solihull. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 925 5555 Facsimile: +44(0)161 925 5500 DX 19866 Altrincham 1.
1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.

Partners: David N Harris LL.B, Ann Alexander LL.B (Hons) M.B.A (Managing Partner), Lesley Herbertson M.A (Cantab), Nicola Castle LL.B (Hons) LLM, Richard Follis LL.B (Hons), Jenny Kennedy, Lindsay Wise B.A (Hons), Grainne Barton LL.B (Hons), Richard Barr, Christian Beadell LL.B (Hons), Auriana Griffiths LL.B (Hons)
Consultant: Prof. Daniel S Simons B.A (Hons) J.D (Member of the Florida Bar)
Associates: Yee Fon Sit LL.B (Hons), Douglas I. Silas LL.B (Hons), Susannah Read LL.B (Hons), Tim Annett LL.B (Hons), Kim Barrett B.A (Hons) LLM, Jonathan Betts LL.B (Hons), Jo Masters LL.B (Hons), *Sue Taylor, *Debbie Murphy RGN, RM, Dip N, *Kirsty R Richards, *Kirsten Limb B.Sc (Hons). *(not a practising solicitor)

Alexander Harris is a franchised firm and a member of the Community Legal Service
Regulated by The Law Society

SCHEDULE OF COMPLAINTS MADE TO GMC

1. Marjorie Bulbeck
2. Emily Yeats
3. Bernard Page
4. Iain Wilson
5. Rita Carby
6. Charles Farthing
7. Gillian McKenzie

Your reference: RF/EP/31243/1/9516

Our reference: MH/misc

21 November 2002

Richard Follis
Alexander Harris Solicitors
Cheriton House
51 Station Road
Solihull
West Midlands B91 3RT

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

names of patients

Dear Mr Follis

Gosport War Memorial Hospital

I write further to your letter of 6 November 2002 and our recent telephone conversation.

You have enquired about complaints made to the GMC by the following clients of yours:

	Name of client	Name of relative
1.	Marjorie Bulbeck	Dulcie Middleton
2.	Emily Yeats	Alice Wilkie
3.	Bernard Page	Eva Page
4.	Iain Wilson	Robert Wilson
5.	Rita Carby	Stanley Carby
6.	Charles Farthing	Arthur Cunningham
7.	Gillian Mackenzie	Gladys Richards

On 12 September 2002 we wrote to clients 2, 3, 4, 6 and 7 to inform them that after considering information received from Hampshire Constabulary concerning the deaths at Gosport War Memorial Hospital of their respective relatives, the Council's Preliminary Proceedings Committee (PPC) decided that the reported actions of Dr Jane Barton be referred to the Professional Conduct Committee for inquiry into whether a charge of serious professional misconduct should be formulated against Dr Barton.

On 9 October 2002 we wrote to Mrs Carby to inform her that her complaint (which was not made available to the PPC due to its late arrival) would be passed to our

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 reference: RF/EP/31243/1/9516

Our reference: MH/misc

21 November 2002

Richard Follis
Alexander Harris Solicitors
Cheriton House
51 Station Road
Solihull
West Midlands B91 3RT

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

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email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

solicitors to assess and to establish whether it could or should be added to those matters already referred by the PPC.

On 7 November 2002 we wrote to Mrs Bulbeck to inform her that, after carefully considering her particular complaint, we had decided that no further action by the GMC was warranted.

I hope that you find this information helpful. Please note that those cases which are currently 'live' are being dealt with in our Conduct Case Presentation Team by my colleague Michael Keegan, tel Code A

Yours sincerely

Code A

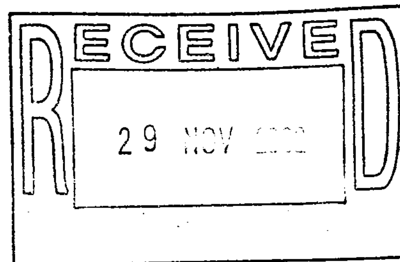
Michael Hudspith
Fitness to Practise Directorate
Direct Line: Code A
Fax Line: 0 Code A
e-mail: Code A

5a

Alexander
Harris
solicitors

Conduct Case Presentation Team
General Medical Council
178 Great Portland Street
London
W1W 5JE

Our ref: RF/PR/31243/1/9516
Your ref:
Please ask for: RICHARD FOLLIS
Direct dial: Code A



28 November 2002

Dear Mr Keegan

Gosport War Memorial Hospital

I thank you for Michael Hudspith's letter of 6 November.

Please find enclosed authorities from the following indicating that they wish us to represent them in GMC proceedings:-

1. Bernard Page
2. Iain Wilson
3. Rita Carby
4. Emily Yeats
5. Gillian McKenzie

Please note our interest and keep us updated as to progress. I am currently awaiting 1 further authority and shall forward this to you as soon as I receive it.

Yours sincerely

Code A

RICHARD FOLLIS
ALEXANDER HARRIS

Code A

Code A

5a

To: The General Medical Council

Your Reference

I, Rita Carby, of Code A wish to be represented in my complaint to the GMC as to the treatment of Stanley Carby by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed.. Code A

Dated ..13-11-02..

5a

To: The General Medical Council
Your Reference

I, Iain Wilson, of Code A wish to be represented in my complaint to the GMC as to the treatment of Robert Caldwell Wilson by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed Code A

Dated 13-11-02

5a

To: The General Medical Council
Your Reference

I, Bernard Page, of Code A wish to be represented in my complaint to the GMC as to the treatment of Eva Isabel Page by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed Code A

Dated 13th November 2002

5a

To: The General Medical Council

Your Reference

I, Emily Yeats, of Code A wish to be represented in my complaint to the GMC as to the treatment of Alice Wilkie by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed Code A ...

Dated ...14.11.02........

5a

To: The General Medical Council
Your Reference

I, Gillian McKenzie, of Code A wish to be represented in my complaint to the GMC as to the treatment of Gladys Richards by Dr Jane Barton at Gosport War Memorial Hospital by my solicitors Alexander Harris of Cheriton House, 51 Station Road, Solihull, West Midlands, B91 3RT.

Signed.. Code A

Dated 27.11.02

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

TRANSMISSION OK

TX/RX NO	2927
CONNECTION TEL	902380599838
SUBADDRESS	
CONNECTION ID	
ST. TIME	15/11 15:51
USAGE T	00'52
PGS. SENT	3
RESULT	OK

FIELD FISHER WATERHOUSE

fax

To:	Major Crime investigation Scheme	Fax:	023 8059 9838
At:		Pages including this one:	3
From:	Judith Chrystie	Date:	15 November 2002
Our ref:	JZC/00492-14742/2118076 v1	Your ref:	

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General Medical Council - Dr J Barton

Please see attached

FIELD FISHER WATERHOUSE

fax

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General Medical Council - Dr J Barton

Please see attached

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 **Fax** +44 (0)20 7488 0084 **e-mail** info@ffwlaw.com **london@thealliance**law.com
www.ffwlaw.com **www.**thealliancelaw.com **CDE** 823
London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

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The partners are either solicitors or registered foreign lawyers.
The European Legal Alliance is an alliance of independent law firms

FIELD FISHER WATERHOUSE

Our Ref: JZC/00492-14742/2118076 v1

Strictly Private & Confidential

DI Nigel Niven
Major Crime investigation Scheme
12-18 Hulse Road
Southampton
SO15 2JX

15 November 2002

Dear Nigel

General Medical Council - Dr J Barton

In anticipation of our meeting at 11.30am on 20 November 2002, I attach a map showing the location of this firm's offices.

I shall attend the meeting together with Michael Keegan, the case-worker at the GMC and my colleague John Offord. John is working on the case with me and will carry out the bulk of any investigative work required for the GMC enquiry.

I look forward to meeting with you then.

Yours sincerely

Code A

Judith Chrystie
Assistant Solicitor
Direct Line: Code A
Code A
Solicitors to the General Medical Council

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The European Legal Alliance is an alliance of independent law firms.

Chrystie, Judith

From: Michael Keegan (7915 7437) **Code A**

Sent: 07 November 2002 13:01

To: **Code A**

Subject: Dr Barton

Judith,

I have been informed by my colleage, Michael Hudspith in Screening, that a complaint about Dr Lord, Consultant at the Gosport War Memorial Hospital, has recently been closed.

Michael Keegan
Conduct Case Presentation Section
Direct Line: **Code A**
Direct Fax:
Email: mkee

LORD: no longer being pursued.

Chrystie, Judith

From: Michael Keegan (7915 7437) Code A
Sent: 07 November 2002 13:01
To: Code A
Subject: Dr Barton

Judith,

I have been informed by my colleage, Michael Hudspith in Screening, that a complaint about Dr Lord, Consultant at the Gosport War Memorial Hospital, has recently been closed.

Michael Keegan
Conduct Case Presentation Section
Direct Line Code A
Direct Fax
Email: mke

FIELD FISHER WATERHOUSE

Our Ref: JZC/00492-14742/2118076 v1

Strictly Private & Confidential

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Major Crime investigation Scheme
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15 November 2002

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Yours sincerely

Code A

Judith Chrystie
Assistant Solicitor
Code A

Solicitors to the General Medical Council

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823

London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

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The partners are either solicitors or registered foreign lawyers.
The European Legal Alliance is an alliance of independent law firms.

Matter BARTON Date 11/1/02

Attending Michael Keegan

Telephone Call	IN	OUT	In Person	

Confirming with Michael Keegan that the meeting was at 11.30am

Action to be taken

Time occupied .... Initials ....

Matter BROWN Date 14/11/02

Attending DI Nigel Niven

Telephone Call | IN | OUT | In Person | |

Call to DI Niven

Confirming meeting and indicating JLL was to fax a map.

DI Niven stating that he may be a few minutes late.

Action to be taken

Time occupied .... Initials ....

Your reference:
In reply please quote MK/2000/2047

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

1 November 2002

Ms Judith Chritie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

RE: DR JANE ANN BARTON

Please find enclosed a copy letter dated 25 October 2002 from Messrs Alexander Harris about Dr Barton (and Dr Lord) and our response of 31 October.

You were to arrange a meeting with the Hampshire Police and, on 22 October 2002 I faxed you a letter I had received with details of the new officer in charge of the investigation. I should be grateful if you would let me know when you manage to make the necessary arrangements for a meeting.

On 7 October 2002 I sent details of complaints regarding Mr Carby and Mrs Gilbertson for you to review and discuss regarding possible inclusion under Rule 11. I also sent you a copy of the CHI report and subsequently advised that Ms Miller at CHI was awaiting confirmation as to what documentation we required.

I am not sure whether you already have a copy, but I enclose a copy of the IOC transcript from 19 September 2002.

I should be grateful for your thoughts on whether the additional complaints should be included, what we should ask from CHI, and for details of arrangements made to meet the Police. You will appreciate my concern about any possible delay in this case. As you know, it is provisionally listed for 7 April 2003.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax:
Email: mke

5a

Alexander
Harris
solicitors

FIRST CLASS
Michael Hudspith
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London
W1W 5JE

ALSO BY FAX

Our ref: RF/LS/31243/1/9516
Your ref:
Please ask for: RICHARD FOLLIS
Direct dial:

25 October 2002

Dear Mr Hudspith

Dr Jane Barton and Dr V Lord – Gosport War Memorial Hospital

We act for **Code A** together with 18 other families who are concerned about events at Gosport War Memorial Hospital.

We understand that a number of complaints have been made to the General Medical Council confined so far as we are aware to the above two doctors. We further understand that certain individual complaints have so far as you are concerned been concluded although it appears from our instructions that others may be ongoing.

We would be grateful if you would please confirm whether there are any and if so what continuing proceedings or investigations on the part of the GMC in relation to either of the above two doctors or arising out of events generally at Gosport War Memorial Hospital.

We anticipate that we may well receive instructions to submit witness statements in support of complaints against Dr Barton and Dr Lord.

We have a meeting with our clients on Sunday 3rd November and would be grateful please for a response in advance of that meeting.

Yours faithfully

Code A

ALEXANDER HARRIS

Alexander Harris, Ashley House, Ashley Road, Altrincham, Cheshire, WA14 2DW Telephone: +44(0)161 925 5555 Facsimile: +44(0)161 925 5500
DX 19866 Altrincham 1. E-mail: info@alexanderharris.co.uk Web Site: www.alexanderharris.co.uk

Also at: 1 Dyers Buildings, London EC1N 2JT United Kingdom Telephone: +44(0)20 7430 5555 Facsimile: +44(0)20 7430 5500 DX 460 London Chancery Lane.
Cheriton House, 51 Station Road, Solihull, West Midlands B91 3RT Telephone: +44(0)121 711 5111 Facsimile: +44(0)121 711 5100 DX 720080 Solihull.

Partners: David N Harris LL.B, Ann Alexander LL.B (Hons) M.B.A (Managing Partner), Lesley Herbertson M.A (Cantab), Nicola Castle LL.B (Hons) LLM, Richard Follis LL.B (Hons), Jenny Kennedy, Lindsay Wise B.A (Hons), Grainne Barton LL.B (Hons), Richard Barr, Christian Beadell LL.B (Hons), Auriana Griffiths LL.B (Hons)
Consultant: Prof. Daniel S Simons B.A (Hons) J.D (Member of the Florida Bar)
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Alexander Harris is a franchised firm and a member of the Community Legal Service
Regulated by The Law Society

Your reference: RF/LS/31243/1/9516

Our reference: 2002/0553

31 October 2002

By fax and post Code A

Richard Follis
Alexander Harris Solicitors
Ashley House
Ashley Road
Altrincham
Cheshire
WA14 2DW

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Mr Follis

Gosport War Memorial Hospital

Thank you for your letter of 25 October 2002 concerning Gosport War Memorial Hospital. I returned from annual leave yesterday and apologise for the delay in responding.

The GMC's consideration of complaints about doctors prior to a public hearing before the Professional Conduct Committee is confidential to the individual complaint and doctor concerned. I am therefore unable to provide any comment about whether complaints made by people other than your client, Code A may be on-going or closed.

As you will be aware, Code A complaint about Dr Barton was considered in June 2002 by both a medical and lay member of the Council. For the reasons outlined in our letter to Code A of 11 June 2002, the members did not consider that her complaint raised any issue of serious professional misconduct or serious professional misconduct on the part of Dr Barton.

You indicate in your letter that you may, in the future, submit witness statements to the GMC in support of further individual complaints. Should you do so I should be grateful if you would forward these for the attention of my colleague, Michael Keegan.

Yours sincerely

Code A

Michael Hudspith
Fitness to Practise Directorate
Direct Line: Code A 7
Fax Line: 0
e-mail: 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

Chrystie, Judith

From: Chrystie, Judith
Sent: 01 November 2002 17:05
To: 'Michael Keegan (7915 7437)'
Subject: RE: Barton

Thank you!

-----Original Message-----
From: Michael Keegan (7915 7437) Code A
Sent: Friday, November 01, 2002 4:27 PM
To: 'Chrystie, Judith'
Subject: RE: Barton

Dear Judith

I'm very sorry. I attach my letter herewith.

I'm happy to travel over to your offices for meeting with police.

Regards

Michael

-----Original Message-----
From: Chrystie, Judith Code A
Sent: 01 Nov 2002 15:50
To: 'Michael Keegan Code A
Subject: RE: Barton

Dear Michael

There was no attachment. Can you send it through to me again so that I can make sure I pick up on any other points in my letter to you!

I have spoken with the Police again. The relevant officers have an appointment in London on that day at some time so will be coming to FFW's offices (or over with you if you'd prefer). They've yet to tie up the time for the other engagement but will firm up in the next few days. I have pencilled off the whole day but will let you know the exact time once I know.

Thanks!

Judith

-----Original Message-----
From: Michael Keegan (7915 7437) Code A
Sent: Friday, November 01, 2002 2:57 PM
To: 'Chrystie, Judith'
Subject: RE: Barton

Judith,

Thanks for that. I coincidentally wrote to you yesterdy (I attach an electronic copy herewith), but you can probably ignore that now.

20th November is fine with me. I'll put it in my diary now. Please let me know the time and arrangements for getting there.

I await your letter and hope that you are feeling better.

Regards

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax: (
Email: mkee

-----Original Message-----
From: Chrystie, Judith Code A
Sent: 01 Nov 2002 14:38
To: ' Code A
Subject: Barton

Dear Michael

I have just received a call from Mr Newdon at the Major Crime Team in Southampton. He apologised for the fact that I have had to repeatedly fax and call to try and arrange a meeting.

He has suggested a meeting on 20 November 2002. Are you available on this day?

I indicated that the suggested date was much later than we would have hoped for given the scheduling of the matter for April 2003. Mr Newdon explained that one of the officers (and indeed I have been advised of this when I have tried to ring him previously) is on annual leave until the middle of next week, that the rest of that week is taken up seeing family members and lawyers on the case and that the following week there are a number of internal procedural matters that are taking up the days.

From the discussions I had with him it does very much appear that the criminal proceedings are ongoing and that the Police are actively and closely scrutinising what happened at Gosport War Memorial Hospital.

I am preparing a detailed letter of advice to you regarding all the other issues in this case. I am sorry that I have not been in communication before now. I am afraid that illness and another long -running hearing have taken me out of the office for much of the last few weeks and although I, and my colleagues on the case, have been able to keep up the chasing calls to the police, I am very conscious that I have not yet replied to you substantively in a number of other regards.

Kind regards
Judith

Judith Chrystie
Professional Regulatory Group
Code A

****
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are addressed. If you have received this email in error please notify
jad@ffwlaw.com

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel: +44(0)207 861 4000
Fax: +44(0)207 488 0084
CDE: 823

Regulated by the Law Society in the conduct of investment business
****

Chrystie, Judith

From: Code A
Sent: 01 November 2002 15:24
To: Chrystie, Judith
Subject: Tel Message

Nigel Noon (Newn) called. He said that if it is okay with you, himself and A.N. Other will be in London on 20th November and would like to meet with you and Michael Keegan. If you would like to go to Hampshire they can facilitate this but he has other business in London and it would be very helpful if the meeting could be here.

Pls call. Code A
Mobile:

Code A

JLC calling his mobile and confirming that London was fine!

Mr Newn to confirm the time in the next few days.

Chrystie, Judith

From: Chrystie, Judith
Sent: 01 November 2002 15:50
To: 'Michael Keegan (7915 7437)'
Subject: RE: Barton

Dear Michael

There was no attachment. Can you send it through to me again so that I can make sure I pick up on any other points in my letter to you!

I have spoken with the Police again. The relevant officers have an appointment in London on that day at some time so will be coming to FFW's offices (or over with you if you'd prefer). They've yet to tie up the time for the other engagement but will firm up in the next few days. I have pencilled off the whole day but will let you know the exact time once I know.

Thanks!

Judith

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From: Michael Keegan (7915 7437) [mailto Code A
Sent: Friday, November 01, 2002 2:57 PM
To: 'Chrystie, Judith'
Subject: RE: Barton

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20th November is fine with me. I'll put it in my diary now. Please let me know the time and arrangements for getting there.

I await your letter and hope that you are feeling better.

Regards

Michael Keegan
Conduct Case Presentation Section
Direct Line Code A
Direct Fax:
Email: mke

-----Original Message-----
From: Chrystie, Judith [mailto Code A
Sent: 01 Nov 2002 14:38
To: Code A
Subject: Barton

Dear Michael

I have just received a call from Mr Newdon at the Major Crime Team in Southampton. He apologised for the fact that I have had to repeatedly fax

GMC100942-0587

and call to try and arrange a meeting.

He has suggested a meeting on 20 November 2002. Are you available on this day?

I indicated that the suggested date was much later than we would have hoped for given the scheduling of the matter for April 2003. Mr Newdon explained that one of the officers (and indeed I have been advised of this when I have tried to ring him previously) is on annual leave until the middle of next week, that the rest of that week is taken up seeing family members and lawyers on the case and that the following week there are a number of internal procedural matters that are taking up the days.

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I am preparing a detailed letter of advice to you regarding all the other issues in this case. I am sorry that I have not been in communication before now. I am afraid that illness and another long -running hearing have taken me out of the office for much of the last few weeks and although I, and my colleagues on the case, have been able to keep up the chasing calls to the police, I am very conscious that I have not yet replied to you substantively in a number of other regards.

Kind regards
Judith

Judith Chrystie
Professional Regulatory Group
Code A

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Fax: +44(0)207 488 0084
CDE: 823

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

TRANSMISSION OK

TX/RX NO	2835
CONNECTION TEL	902380599838
SUBADDRESS	
CONNECTION ID	
ST. TIME	01/11 14:29
USAGE T	00'49
PGS. SENT	3
RESULT	OK

FIELD FISHER WATERHOUSE

fax

To:	DCI Robert Barton	Fax:	023 80599838
At:		Pages including this one:	3
From:	Judith Chrystie	Date:	1 November 2002
Our ref:	JZC/00492-14742/2096716 v1	Your ref:	

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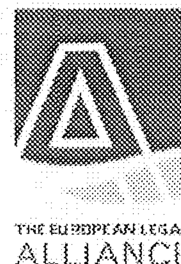
General Medical Council - Dr J Barton

Please see attached

FIELD FISHER WATERHOUSE



fax

To: DCI Robert Barton	Fax: 023 80599838
At:	Pages including this one: 3
From: Judith Chrystie	Date: 1 November 2002
Our ref: JZC/00492-14742/2096716 v1	Your ref:

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General Medical Council - Dr J Barton

Please see attached

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823
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Our Ref: JZC/00492-14742/2096716 v1

DCI Robert Barton
Major Crime Investigation Team
12-18 Hulse Road
Southampton
SO15 2JX

1 November 2002

Dear Mr Duncan

General Medical Council - Dr J Barton

I understand that you are co-ordinating the criminal investigations into the conduct of Dr Jane Barton.

I attach a letter dated 11 October 2002 that I faxed to Chief Superintendent James. I have not received any acknowledgement nor a response to the letter.

The matter is provisionally scheduled for hearing before the General Medical Council's Professional Conduct Committee in April 2003. The matter will, of course, be adjourned if police enquiries are ongoing. I am anxious to pursue investigations on behalf of the GMC and should be grateful if you could contact me as a matter of urgency.

Yours sincerely

Code A

Assistant Solicitor
Direct **Code A**
Email:

Solicitors to the General Medical Council

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823

London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

FILE COPY

Our ref: JZC/MJM/00492-14742/2064930 v1
Your ref: MIC/det.supt/jj/dm

Confidential

DSI J James
Major Incident Complex
Kingston Crescent
North End
Portsmouth PO2 8BU

11 October 2002

Dear DSI James

General Medical Council: Dr J Barton

I am a solicitor at the firm Field Fisher Waterhouse. The firm is instructed to act on behalf of the General Medical Council in respect of investigations into the conduct of Dr Jane Barton.

I understand that you are the officer with conduct of the case. I should be grateful if you could contact me in order to discuss how we can cooperate and liaise with our investigations.

My direct dial number is listed below and I should be grateful if you could contact me at your earliest convenience.

Yours sincerely

Judith Chrystie

Code A

Matter BARTON Date

Attending DCI Duncan

Telephone Call	IN	OUT	In Person	

DCI Duncan is on annual leave until 06/11.

His colleague may be able to deal with the matter

JLC to fax. Explaining she had sent a fax

in early Oct to Chief Superintendent James.

Action to be taken

Time occupied .... Initials ....

Fax

22 OCT '02 12:59
P/H 3rd

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

To Judith Chritie

Fax number 7438 0064

From Michael Keegan

Direct Dial **Code A**

Direct fax

No. of pages (inclusive) 2 *Time* 13:00 *Date* 22 October 2002

Dear Judith

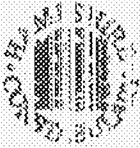
RE: DR BARTON

Please find attached letter dated 16 October 2002 from Hampshire Constabulary, which is self-explanatory.

I should be grateful if you would let me know when you manage to arrange for us to meet with the appropriate officer/s.

Michael Keegan
Conduct Case Presentation Section
Direct Line: **Code A**
Direct Fax:
Email: mike

GMC100942-0594



HAMPSHIRE CONSTABULARY

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

Western Area Headquarters
12-18 Hulse Road
Southampton
Hampshire
SO15 2JX

Tel. 0845 04554545
Fax. 023 80599838

Our Ref:

Your Ref:

16th October 2002

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Dear Mr Keegan,

Thank you for your letter to Chief Superintendent James dated 17th September 2002.

This letter is to inform you that Detective Chief Superintendent Watts, has now been appointed the Senior Investigating Officer into matters relating to Gosport War Memorial Hospital.

The enquiry is being co-ordinated by myself, Detective Chief Inspector Robert Duncan of the Major Crime Team, 12-18 Hulse Road, Southampton, S015 2JX. My direct telephone number is:-

02380 674113

If I can be of any further assistance please contact me on the above number.

Yours sincerely

Code A

Robert Duncan
Detective Chief Inspector
Major Crime Investigation Team

Matter GMC001 Date 15/10/02

Attending Michael Keegan

Telephone Call | IN | OUT | In Person

(1) [illegible] — Mr Baker a [illegible] (annual) to reach late 01/10/02 — re listing

(2) Northwest's response re IOC has arrived

(3) CMS documents — Has discussed with CMA
(a) Statements — they will get [illegible] approval
(b) Other [illegible] (papers) — [illegible] look to see what we want ...

Action to be taken

Time occupied .... Initials ....

(4) Indicate under Rule 11(2) ? TLC confirming that we had rec'd the other complaints but that owing to her involvement in Tenbury she had been unable to examine the complaints.

(5) TLC advising she had contacted the police and had sent a fax — she will get a meeting arranged as soon as possible.

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

TRANSMISSION OK

TX/RX NO	2780
CONNECTION TEL	902392891884
SUBADDRESS	
CONNECTION ID	
ST. TIME	13/10 16:52
USAGE T	00'38
PGS. SENT	2
RESULT	OK

FIELD FISHER WATERHOUSE

Confidential

fax

To:	**DSI J James**	Fax:	**02392 891884**
At:	**Major Incident Complex**	Pages including this one:	**2**
From:	**Judith Chrystie**	Date:	**11 October 2002**
Our ref:	**JZC/MJM/00492-14742/2064930 v**	Your ref:	**MIC/det.supt/jj/dm**

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General Medical Council: Dr J Barton

FIELD FISHER WATERHOUSE

Confidential

fax

To:	**DSI J James**	Fax:	**02392 891884**
At:	**Major Incident Complex**	Pages including this one:	**2**
From:	**Judith Chrystie**	Date:	**11 October 2002**
Our ref:	**JZC/MJM/00492-14742/2064930 v**	Your ref:	**MIC/det.supt/jj/dm**

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General Medical Council: Dr J Barton

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 **Fax** +44 (0)20 7488 0084 **e-mail** info@ffwlaw.com **london@thealliancelaw.com**
www.ffwlaw.com **www.**the**alliance**law.com **CDE** 823
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Our ref: JZC/MJM/00492-14742/2064930 v1
Your ref: MIC/det.supt/jj/dm

Confidential

DSI J James
Major Incident Complex
Kingston Crescent
North End
Portsmouth PO2 8BU

11 October 2002

Dear DSI James

General Medical Council: Dr J Barton

I am a solicitor at the firm Field Fisher Waterhouse. The firm is instructed to act on behalf of the General Medical Council in respect of investigations into the conduct of Dr Jane Barton.

I understand that you are the officer with conduct of the case. I should be grateful if you could contact me in order to discuss how we can cooperate and liaise with our investigations.

My direct dial number is listed below and I should be grateful if you could contact me at your earliest convenience.

Yours sincerely

Code A

Code A

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823

London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

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The European Legal Alliance is an alliance of independent law firms.

Matter BARTON Date 03/10/02

Attending DS James

Telephone Call | IN | OUT | In Person

being put through to a number of phones
being advised to send a fax

Action to be taken

Time occupied .... Initials ....

PH 3rd
16 OCT '02 9:48

Fax

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

To: Ms Judith Chritie
Fax number: Also by fax: 020 7488 0084
From: Michael Keegan
Direct Dial: Code A
Direct fax:
No. of pages (inclusive): 4 09:45 *Date* 16 October 2002

Dear Judith

Re: Dr J A Barton

Please find attached copy of fax from Julie Miller at CHI, which is self-explanatory.

I await your call once you have reviewed the additional papers I recently sent to discuss what we can usefully request of CHI and our proposed meeting with Hampshire police.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax:
Email: mke

178 Great Portland Street London W1N 6JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

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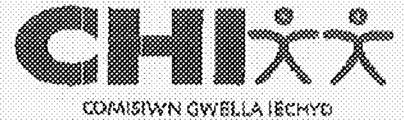

COMISIWN GWELLA IECHYD

Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG
Ffôn: 020 7448 9200
Ffacs: 020 7448 9222
Testun Ffôn: 020 7448 9292
www.chi.nhs.uk

To Michael Keegan.
Re Dr Barton

Hope this is useful – we have contact addresses. Would prefer to ask individuals if OK for you to contact them if possible.
Let me know if can help further.

Julie Miller

Code A

DOES NOT INCLUDE - VOL ORGS -

Summary of Stakeholder details who had Negative experiences

Wednesday 21 Nov 2002- Gosport	Thursday 22nd November- Portsmouth	Telephone Interviews
Mrs Ripley **Relative:** Mr Ripley (husband) **Ward:** **Partic:** Nearly killed husband. The husband had verybad arthritis and gout and Mrs Ripley feel they nearly gave him an overdose. An official compliant was issued but received a half hearted apology.	Mr J Pitthard & MR OLDROYD. **Relative:** Mr Nat Gonella (friend deceased) **Ward:** One of the Three **Partic** Very upset about the death of Mr Gonella three years ago.	Mrs Jackson **Relative:** Alice Wilkes (mother deceased) **Ward:** Deadalus **Partic** Mrs Richards & Mrs McKenzie **Relative:** Gladys Rochards (deceased) **Ward:** Daedauls **Partic**
Mrs Bulbeck **Relative:** Mother (Deceased) **Ward:** Daedalus **Partic:**	Mrs Deedman and Bereavement Councillor **Relative:** Mr Deedman (Husband Deceased) **Ward:** Daedalus. **Partic**	Mr Tim Welstead **Relative:** Father (deceased) **Ward:** Mulberry Ward **Partic**
Mr Page **Relative:** Eva Page (mother deceased) **Ward:** Daedalus **Partic:**	**Friday 23rd November – Portsmouth** Mr Ian Wilson **Relative:** Father (deceased) **Ward:** Daedalus / dryad. **Partic**	Mrs Blackwell **Relative:** Husband **Ward:** Collingwood **Partic** Mrs Reeves **Relative:** Elsie Devine (mother) **Ward:** Daedalus **Partic**

GMC100942-0603

Mrs Grahame **Relative:** Mr Grahme (Husband deceased) **Ward:** **Partic:** Concerned about treatment and death of her husband.	Mr Mitchell and Ms Wendy Mitchell **Relative:** Mr Mitchell (Father deceased) **Ward:** one of the three **Partic**	Mrs Bright **Relative:** Mother **Ward:** Deadalus **Partic**
Mr Wilson **Relative:** Edna Purnell (mother deceased) **Ward:** Daedalus **Partic:** Care and administration of diamorphine	Mr Abery **Relative:** Wife **Ward:** Dryad and Deadulus **Partic** On the Dryad ward the Staff Nurse interfered with drugs Q+A reduced prescription drugs by two thirds Deadulas did increase prescription but still effected wife.	Mrs Lovejoy **Relative:** Husband **Ward:** Collingwood **Partic** Sheena Windsor **Relative:** Norma Wilson (Mother deceased) **Ward:** Sultan **Partic**

<u>Stakeholder with Positive experiences</u>

Allan Smith-	Wife and himself	Mrs Purvis	Mother
R.B Brewster	Husband	Mr Nelson	Husband and Mother
Anon	Husband	Mrs Lesley	Husband
P Chase	Husband	Mrs Tyell	Mother and herself
H M Ord	Brother –in Law	Mrs Fitzpatric	friend

GMC100942-0604

GENERAL
MEDICAL
COUNCIL
Protecting patients,
guiding doctors

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

7 October 2002

Ms Judith Chritie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

RE: DR JANE ANN BARTON

Further to our recent case conference, I enclose a copy memorandum from my colleague regarding cases arising from the Gosport War Memorial Hospital that have not been referred to the PPC. In particular, two cases are identified as new and potentially relevant to Dr Barton, namely those relating to Mr Carby and Mrs Gilbertson.

I enclose copy correspondence from the files created in relation to those two cases. In the case of Mr Carby, many of the documents had notes attached. Where these obscured the underlying text I have copied the documents both with and without the notes.

Having reviewed the CHI report I fear that I may have requested too much in my letter to Ms Miller that I copied to you! No doubt Ms Miller will contact me and we can discuss the extent of documents that are actually usefully required. I would welcome the opportunity to discuss the same with you once you have had the chance to review the CHI report yourself.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line:
Direct Fax: Code A
Email: mke

Memorandum

Out	Back

Ref: **2000/2047**
To: **Venessa Carrol**
Michael Keegan

From: **Michael Hudspith**
Code A

Copy: **Peter Swain**

Date: **3 October 2002**

Dr Jane Barton (1587920)

Peter/Venessa - we spoke and agreed that I would provide a summary of all the 'Barton-related' issues that screening is aware of but which did not feature in the recent PPC item papers.

The PPC considered charges against Dr Barton based on her management of 5 elderly patients (Eva Page, Alice Wilkie, Gladys Richards, Arthur Cunningham and Robert Wilson) on Daedalus/Dryad Wards at Gosport War Memorial Hospital between February and October 1998. These cases were referred to the GMC by Hampshire Constabulary with each case study being supported by an independent expert opinion(s) critical of Dr Barton .

In addition to the 5 'police' cases, the following information was or has also been brought to our attention:

1. **(2000/0247/03)** - In **(date)** Mr Mike Wilson wrote to the GMC about the death of his mother, Mrs Purnell, who died on Dryad Ward on **(date)** following her transfer to the Gosport War Memorial Hospital for rehabilitation.

   Mr Wilson's complaint concerns failures in communication by hospital staff and as well as his mother's clinical car, particularly relating to prescribing. Although specifically naming Dr Barton in his complaint, the available records appeared to show that Dr Barton was only one of a number of doctors who reviewed and prescribed for Mrs Purnell. Unfortunately only limited records are available as a section of the records were erroneously destroyed by the Trust during microfilming in April 1999.

   By the time Mr Wilson wrote to the GMC Mrs Purnell's care had already been reviewed both locally and by the Health Service Ombudsman. Both reviews sought independent medical advice and both considered Mrs Purnell's treatment to have been acceptable in the circumstances. On the information available, the screeners considered that the complaint raised no issue of spm on the part of Dr Barton.

2. **(2002/0553)** - In February Mrs Ann Reeves wrote to the GMC about the death of her mother, Elsie Devine, who died on Dryad Ward in November 1999 a few weeks after being admitted for respite care.

Whilst specifically naming Dr Barton in her complaint, Mrs Reeves complains of failures in communication by hospital staff as well as her mother's clinical care. By the time Mrs Reeves wrote to the GMC Mrs Devine's care had already been reviewed both locally and by the Health Service Ombudsman. Both reviews sought independent medical advice and both considered Mrs Devine's clinical treatment to have been acceptable in the circumstances. On the information available, the screeners considered that the complaint raised no issue of spm on the part of Dr Barton.

I should add that Mrs Reeves is currently seeking legal advice with a view to a possible civil claim. Her solicitors have requested that should we need to contact Mrs Reeves, we do it through them:

Alexander Harris Solicitors (contact Lisa Elkin), Ashleigh House, Ashleigh Road, Altrincham, Cheshire WA14 2DW

3. **(2002/1345)** - In June 2002 Mrs R E Carby wrote to the GMC concerning the death of her husband, Stanley Carby, who died on Daedalus Ward in April 1999 shortly after being admitted for 'rehabilitation'. After her husband's death Mrs Carby met with representatives of the Trust to discuss her concerns but was not satisfied with their responses.

Whilst specifically naming Dr Barton in her complaint Mrs Carby writes mainly of inconsistencies or inaccuracies in her husband's medical and nursing records and failure's in communication by hospital staff. Of perhaps more concern to the GMC would be the wide range of drugs written up for this patient by Dr Barton shortly after his admission and whether the manner of her prescribing was in any way inappropriate of irresponsible.

In order to properly assess whether this case raises any issues of spm against Dr Barton (or any other doctor) I would suggest we would need to obtain an expert opinion.

4. **(2002/~~1068~~ 1608)** - In July 2002 CHI published their report into the treatment of elderly patients at the Gosport War Memorial Hospital between 1998 and 2001. Whilst the report criticised a failure of Trust systems to ensure good quality patient care during this period, the Report does not apportion blame to specific individuals or mention them by name.

However, page 5 of the report makes reference to 10 complaints made to the Trust since 1998. We requested details of these complaints and

discovered that the majority were either made but individuals who subsequently wrote to the GMC or were about matters not related to our case. Only one complaint, made by a Mrs Batson in 2000 concerning the death of her mother, Mrs Gilbertson, on Dryad Ward in December 1999, appeared relevant and we recently requested and received further details. Whilst the complaint raises a number of different issues, Mrs Batson does raise the issue of pain relief (oral morphine) and mentions Dr Barton by name.

It would appear however that Mrs Batson was satisfied by the response of the Trust to her complaint and chose not to pursue the matter further.

Matters 1 and 2 are brought to your attention for background information only. With regard to matters 3 and 4 I understand that it may be open to us to consider adding these cases under Rule 11 to those matters already referred up by the PPC?

Should you have further any questions concerning any of the above, please don't hesitate to contact me.

Code A

GENERAL
MEDICAL
COUNCIL
Protecting patients,
guiding doctors

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

8 October 2002

Ms Judith Chritie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

RE: DR JANE ANN BARTON

I write to confirm that the Professional Conduct Committee meeting to consider the case against Dr Barton has been provisionally listed for three weeks commencing 17 March 2002.

Further to my letters dated 4 and 7 October, Ms Miller at CHI called today to discuss which documents from the extensive appendix attached to their report, as well as records of interviews, etc., we actually require. I should be grateful if you would contact me to discuss the same as soon as possible. Ms Miller indicated that, if we requested records of CHI's interviews with members of the patients' families, she would wish to contact them before releasing the documents to us.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax:
Email: mke

GENERAL
MEDICAL
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*Protecting patients,
guiding doctors*

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

4 October 2002

Ms Judith Chritie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

RE: DR JANE ANN BARTON

Further to yesterday's case conference, please find enclosed a copy of the CHI report and my letter to Ms Miller at CHI requesting the background information.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Lin[Code A]
Direct Fax
Email: mk

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Your reference:
In reply please quote MK/2000/2047

Please address your reply to Conduct Case Presentation Section, FPD
Fax 020 7915 3696

4 October 2002

Ms J Miller
Commission for Health Improvement
103 – 105 Bunhill Row
London EC1Y 8TG

Dear Ms Miller

Re: Dr J A Barton

As you already know, the Council's Preliminary Proceedings Committee recently referred the case of Dr Barton for inquiry by the Professional Conduct Committee and we are now preparing for that.

I already have a copy of the CHI report on the Gosport War Memorial Hospital dated July 2002. When we last spoke you indicated that you would be prepared to make available the background documentation gathered and prepared by yourselves and I should now be grateful if you would copy the same to me as soon as possible.

If you wish to discuss this matter please do not hesitate to contact me on the number below.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section
Direct Line:
Direct Fax:
Email: mke
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

FIELD FISHER WATERHOUSE

Our ref: JZC/MJM/00492-14742/2064930 v1
Your ref: MIC/det.supt/jj/dm

Confidential

DSI J James
Major Incident Complex
Kingston Crescent
North End
Portsmouth PO2 8BU

11 October 2002

Dear DSI James

General Medical Council: Dr J Barton

I am a solicitor at the firm Field Fisher Waterhouse. The firm is instructed to act on behalf of the General Medical Council in respect of investigations into the conduct of Dr Jane Barton.

I understand that you are the officer with conduct of the case. I should be grateful if you could contact me in order to discuss how we can cooperate and liaise with our investigations.

My direct dial number is listed below and I should be grateful if you could contact me at your earliest convenience.

Yours sincerely

Code A

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823

London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

Regulated by the Law Society. A list of the names of the partners of FFW and their professional qualifications is open to inspection at the above office.
The partners are either solicitors or registered foreign lawyers.
The European Legal Alliance is an alliance of independent law firms.

Matter BROWN Date 10/10/02

Attending Michael Vaggers

Telephone Call	IN	OUT	In Person	

Call to Michael at GMC

Leaving message for him to call

Action to be taken

Time occupied .... Initials ....

FIELD FISHER WATERHOUSE

attendance note

Name: Judith Chrystie	Type: Meeting
Duration:	Date: 3rd October 2002

Attendees:

GMC: Peter Swain
Michael Keegan

FFW: MSL
JZC

Meeting

Issues

MSL identifying the fact that there were five issues that he particularly wished to discuss with the GMC and that these were as follows:

1. 1991 Allegations
2. Timescale
3. Further Cases
4. Dr. Lord
5. Police Involvement

1991 Allegations

MSL indicating that he doubted that the further information received by the GMC and passed to MSL regarding the 1991 allegations would add anything to the case and would not be sufficient evidence to add weight to an argument for an Interim Order.

MSL advising that, technically, the information regarding the 1991 allegations was new evidence and did show that the concerns were long-standing. MSL advising that although the new information could be regarded as "trigger papers" there was an abuse point and it was possible that the Screener would determine that they did not add anything to the weight of the existing allegations.

PS and MSL identifying the fact that there was a political aspect to this case and that local individuals, such as Mike Gill were under some pressure. MSL advising that he would provide written advice on the issue on headed FFW paper.

Timescale

The attendees accepting that the speed with which the matter could be progressed would be effected by the police investigation and any prosecution by the CPS. It was identified that it may be helpful if the police could provide the papers on the understanding that the GMC would do nothing with the information until the conclusion of the prosecution or investigation. This would, however, enable the GMC to be ready to "roll out" the matter quickly once there was no prejudice to the regulatory inquiry.

MSL requesting an update about the police investigation if the GMC had recently received one. MK stating that it appeared that nothing much had changed; the matter had been submitted to the CPS and unofficial it appeared that the matter would not proceed.

The parties agreeing that an early meeting with DSI James would be useful in order to establish what was going on. JZC to arrange a meeting with the police.

The parties discussing the level of Counsel to become involved in the case. The GMC accepting that owing to the public profile of the case it would be beneficial to instruct a QC at an early stage.

JZC suggesting that the matter could be listed for March if we were able to progress investigations.

MSL pointing out that the report prepared by CHI would provide useful background information; FFW would wish to see everything that the investigators for CHI had obtained. Noting that the CHI report may have helpful information and statements that could be utilised. In addition, CHI may have obtained the necessary consents from witnesses and relevant medical records.

MK to provide JZC with all the information regarding the CHI report.

Dr Lord and Further Cases

The parties discussing the difficulties that would be presented by the fact that both Dr. Lord (Dr. Barton's Consultant) and the nurses involved with the case may be the subject of regulatory proceedings through the GMC and the UKCC. Advising that it would not be possible for these individuals to give evidence at any regulatory proceedings as to do so would be to give evidence which could potentially self-incriminate the individual.

MK advising that owing to media coverage, further cases had been received by the GMC. These were currently being considered by Mike Hudspith.

MSL suggesting that all the new complaints were sent through to FFW in order to investigate and decide whether it was possible to push them through to the hearing under Rule 11(2). Noting that there would be some concern as to when the complaints were received and whether these were after the Rule 6 letter but before the PPC.

JZC suggesting it would be helpful for her to pop through to the GMC to enable her to analyse the GMC's current file and identify any information that should be considered by FFW.

MSL suggesting that we would make enquiries with the UKCC in order to identify what the position was regarding the complaints against the nurses.

General

MSL advising MK and PS that the case provided by Dr. Barton to the IOC was "*very powerful*". Neither MK or PS had read the IOC transcript or response letter and MSL and JZC suggesting that they did so as owing to the particular resource issues identified in Dr. Barton's response, it may be difficult to attach sole blame for hastening death to the doctor. MSL noting, however, that following receipt of the 1991 allegations, it was clear that there had been long-standing concern regarding treatment by Dr Barton which resulted in the ending of life. The parties agreeing that there did appear to be problems with the doctor's practice but this may not be a 'Shipmanesque' case.

PS stating that this was a case in which there was indirect pressure from external sources for the GMC to push on with its enquiries - PS emphasising that there was no agenda being pursued to achieve a particular result. The GMC would, however, have to ensure that all matters were fully explored.

GMC100942-0617

Chrystie, Judith

From: Chrystie, Judith
Sent: 19 September 2002 16:02
To: 'Michael Keegan (7915 7437)'
Subject: RE: Dr Barton

Thanks. I've booked a room for us all.

Look forward to meeting with you then.

Judith

-----Original Message-----
From: Michael Keegan (7915 7437) [mailto: Code A
Sent: Thursday, September 19, 2002 4:28 PM
To: 'Chrystie, Judith'
Subject: RE: Dr Barton

Judith,

I can confirm that the IOC made no order today.

I am also able to confirm the proposed date, time and venue for the case conference.

Thanks

-----Original Message-----
From: Chrystie, Judith [mailto: Code A
Sent: 19 Sep 2002 13:53
To: 'Michael Keegan (7915 7437)'
Subject: RE: Dr Barton

Dear Mr Keegan

Thank you for your email.

I am available on any day in week commencing 30 September 2002 but I am aware that Matthew Lohn would also like to be involved in the conference and he has a number of meetings already scheduled for that week. Are you, Venessa and Peter available on Thursday 3 October 2002 at 2.30pm?

Would it be possible for the meeting to take place at FFW offices? Unfortunately Matthew will have undergone two knee operations by the 3rd and it would make life (and pain!) considerably easier for him if we could hold the meeting here.

Please do call if you would like to discuss the matter.

Kind regards
Judith

Judith Chrystie
Professional Regulatory Group
Code A

5539/07970 165549) at Portsmouth Health Authority regarding a further development in this case.

On Tuesday (17th) following the announcement about the CMO audit, ST met with Dr Barton to ensure that she was not working at the moment. Sir Liam Donaldson had indicated that voluntary restrictions on Dr's prescribing should be reintroduced. I understand that the vol undertaking had ceased following last decision of IOC to place no order. ST assured that Dr currently currently on sick leave.

Followign his mtg with Dr B, ST met with the staff at Gosport Hospital when 2 nurses handed over a dossier of files/letters which refer to concerns about the Dr's prescribing back as far as 1991 (as you know the current allegs relate to 1998). Included in the file are copies of minuted meetings, correspondence with the Royal College of Nursing and the Chief Executive. The report names individuals for example the CE of East Hants PCT. What this report suggests is that concerns were raised back as far as 1991 and people failed to act. By way of example, ST told me that the first page of the report which relates to a nurses mtg in 1991 refers to patients being given diamorphine when they had no pain, indiscriminate use of a syringe driver, and patients' deaths being hastened. The report has been copied to the Police and the CMO and a copy will be sent to me.

I informed ST that the IOC is today considering Dr B's case and I would notify him, as well as Mike Gill, of the outcome.

Venessa

-----Original Message-----
From: Michael Keegan (7915 7437) Code A
Sent: Thursday, September 19, 2002 11:34 AM
To: Code A
Subject: FW: Dr Barton

Ms Chrystie,

I have recently been appointed as a Senior Caseworker with the CCPS in the GMC.

I understand that you have been instructed by the Counil in relation to Dr Barton.

I have been asked to arrange an early case conference with you involving Peter Swain, Venesa Carroll and I. May I suggest the week after next.

If you wish to discuss the matter please telephone me on the number below.

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax:
Email: mke

-----Original Message-----
From: Peter Swain Code A
Sent: 19 Sep 2002 10:12
To: Venessa Carroll Code A; Paul Philip Code A
Cc: Michael Keegan Code A
Subject: RE: Dr Barton

Venessa

Thanks. We will have to consider the tactics of this. Usually, we hear the substantive case first, and then assess on the basis of the findings whether others have a case to answer for not reporting concerns earlier. However, this runs the risk that witnesses in the substantive case will not give evidence for fear of incriminating themselves. We overcame this in the Bristol case by charging the Chief Exec at the same hearing as the other doctors.

We need some early dialogue with the instructed solicitors. Please keep me informed; I will want to attend all case conferences for this case.

Peter

-----Original Message-----
From: Venessa Carroll (Code A
Sent: 19 Sep 2002 09:38
To: Peter Swain (7915 3582); Paul Philip Code A
Cc: Michael Keegan Code A
Subject: Dr Barton
Importance: High

Peter and Paul

I have just spoken with Simon Tanner, Director of Public Health (023 8072

Matter BROWN Date 19/09/02

Attending Michael Keegan

Telephone Call	IN	OUT	In Person	

Confirmation of meeting on 03/10/02 @ 2.30pm @ GMC

IOC:
Made no order

CSE booking (10)

Action to be taken

Time occupied .... Initials ....

GMC100942-0621

Fax

To Judith Chritie
Messrs Field Fisher Waterhouse

Fax number 020 7861 4356

From Michael Keegan

Direct Dial
Direct fax **Code A**

No. of pages (inclusive) 29 12:20 Date 3 October 2002

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Further to our telephone conversation, please find attached the MDU's response on behalf of Dr Barton to the PPC item.

178 Great Portland Street London W1N 6JE

Chrystie, Judith

From: Chrystie, Judith
Sent: 02 October 2002 17:46
To: Code A

Dear Michael

The papers relating to Barton do not contain the Rule 6 response. Could you please fax over a copy to me this evening or tomorrow morning so that Matthew and I can consider the Doctor's reply before our meeting.

Many thanks.
Judith

Fax: 020 7488 0084

Judith Chrystie
Professional Regulatory Group
Code A

Chrystie, Judith

From: Chrystie, Judith
Sent: 23 September 2002 11:34
To: Code A
Subject: BARTON

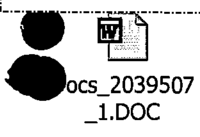
Importance: High

Dear Lorna

Please find attached IIS for Dr Barton

Best wishes
Judith

Judith Chrystie
Professional Regulatory Group
Code A



ocs_2039507_1.DOC

Annex A

Investigation Instruction Sheet (IIS) Post Preliminary Proceedings Committee Case	
Section A – to be completed by the GMC	
Priority Band: **A** – also referred to IOC. The doctor is to be offered voluntary erasure so please do not list yet.	
1. Date of instructions to solicitor:	Field Fisher Waterhouse
1. Name of doctor:	Dr Jane Ann BARTON
2. GMC file number:	2000/2047
3. Name of GMC CW: Direct line	Michael Keegan 020 7915 7437
4. Type of case:	Conduct
5. Date for instructed solicitor to complete Section B (one week from the date of these instructions):	23 September 2002
6. Other comments:	London
Section B – to be completed by the instructed solicitor within one week of the date of these instructions.	
7. Name of investigator:	John Offord (Investigator); Judith Chrystie (Solicitor)
8. Estimated number of witnesses:	12 - 15 witnesses of fact 1-3 expert witness
9. Class of case (1-5, see protocol):	Class 4
10. Target date for completion (see protocol):	6 January 2003
11. Earliest date case may be listed (taking into account the Carlile protocol):	Mid-late March 2003
12.Listing comments:	London Venue preferable owing to location of witnesses
13. Date IIS submitted by solicitor:	23 September 2002

NEW MATTER FORM

THIS FORM MUST BE COMPLETED IN FULL - FAILURE TO DO SO MAY RESULT IN DELAY

CLIENT NAME GENERAL MEDICAL COUNCIL

CLIENT NUMBER 00492 MATTER NUMBER 14742 (for accounts use only) (check digit)

MATTER PARTNERS INITIALS MSL FEE EARNERS INITIALS 12C WORK TYPE 102 PROFIT CENTRE 501

GMC CATEGORY C

MATTER NAME DR BARTON J A

IS THE CLIENT ELIGIBLE FOR LEGAL AID? DOES DEPOSIT INTEREST APPLY?

HAS THE CLIENT'S WRITTEN AGREEMENT BEEN OBTAINED TO OPT OUT OF THESE RULES?

SEARCH REQUIRED FOR OTHER PARTY? CONTROLLED TRUST

IF YES, NAME OF OTHER PARTY/SIDE

(Relevant for contentious or transactional matters. If not known at this stage please notify Accounts as soon as it is.)

If no match Accounts will check file storage records

FILE STORAGE RECORDS CHECKED?

ARE YOU SATISFIED THERE IS NO CONFLICT OF INTEREST?

COSTS PAYABLE BY THIRD PARTY?

CREDIT LIMIT Do credit limits apply to this matter? If so, which credit limit applies?

0 | £1k | £2k | £3k | £4k

HAVE YOU CONSIDERED MONEY LAUNDERING REGULATIONS WITH REGARD TO THIS MATTER?

HAVE YOU SENT A CLIENT CARE LETTER?

IF NOT, WHY NOT?

IS THE CLIENT INFORMATION IS UP-TO-DATE?

Completed by ______ Matter Partner Signature Code A Date 3/9/02

Input by Accounts (initials) ______ Input by Marketing (initials) ______

NEW MATTER FORM

THIS FORM MUST BE COMPLETED IN FULL - FAILURE TO DO SO MAY RESULT IN DELAY

CLIENT NAME: GENERAL MEDICAL COUNCIL

CLIENT NUMBER: 00492

MATTER NUMBER: 14742 *(for accounts use only)*

(check digit)

MATTER PARTNERS INITIALS: MSL | FEE EARNERS INITIALS: JZC | WORK TYPE: 102 | PROFIT CENTRE: 501

GMC CATEGORY: C

MATTER NAME: DR BARTON J A

IS THE CLIENT ELIGIBLE FOR LEGAL AID? DOES DEPOSIT INTEREST APPLY?

HAS THE CLIENT'S WRITTEN AGREEMENT BEEN OBTAINED TO OPT OUT OF THESE RULES?

SEARCH REQUIRED FOR OTHER PARTY? CONTROLLED TRUST

IF YES, NAME OF OTHER PARTY/SIDE

(Relevant for contentious or transactional matters. If not known at this stage please notify Accounts as soon as it is.)

If no match Accounts will check file storage records

FILE STORAGE RECORDS CHECKED?

ARE YOU SATISFIED THERE IS NO CONFLICT OF INTEREST?

COSTS PAYABLE BY THIRD PARTY?

CREDIT LIMIT Do credit limits apply to this matter? If so, which credit limit applies?

0		£1k		£2k		£3k		£4k	

HAVE YOU CONSIDERED MONEY LAUNDERING REGULATIONS WITH REGARD TO THIS MATTER?

HAVE YOU SENT A CLIENT CARE LETTER?

IF NOT, WHY NOT?

IS THE CLIENT INFORMATION IS UP-TO-DATE?

Completed by ______ Matter Partner Signature **Code A** Date 17/9/02

Input by Accounts (initials) ______ Input by Marketing (initials) ______