Field Fisher Waterhouse

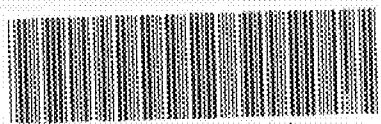
FFW/149/01

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

GENERIC CASE FILE
(2)



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GENERAL MEDICAL COUNCIL

-and-

DR BARTON

GENERIC CASE FILE (2)

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OPERATION ROCHESTER

Investigation Overview 1998-2006.

Background.

Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed during much of the period under investigation by the Fareham and Gosport Primary Care Trust. The hospital fell under the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002 when services were transferred to the local Primary Care Trust.

The hospital operates on a day-to-day basis by nursing and support staff employed by the PCT. Clinical expertise was provided by way of visiting general practitioners and clinical assistants, consultant cover being provided in the same way.

Elderly patients were generally admitted to GWMH through referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

Doctor Jane BARTON is a registered Medical Practitioner who in 1988 took up a part-time position at GWMH as Clinical Assistant in Elderly Medicine. She retired from that position in 2000.

Police Investigations.

Operation ROCHESTER was an investigation by Hampshire Police into the deaths of elderly patients at GWMH following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at levels or under circumstances that hastened or caused death. There were

further concerns raised by families of the deceased that the general standard of care afforded to patients was often sub-optimal and potentially negligent.

Most of the allegations involved a particular General Practitioner directly responsible for patient care Doctor Jane BARTON.

Two allegations (SPURGIN and PACKMAN) were pursued in respect of a consultant Dr Richard REID.

Of 945 death certificates issued in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Doctor BARTON.

The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

The General Medical Council also heard evidence during Interim Order Committee Hearings to determine whether the registration of Dr BARTON to continue to practice should be withdrawn. On each of the three occasions that the matter was heard the GMC was satisfied that there was no requirement for such an order and Dr BARTON continued to practice under voluntary restrictions in respect of the administration of Opiate drugs.

<u>The First Police investigation.</u>

Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91 years.

Mrs. Richards died at the GWMH on Friday 21st August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

Following the death of Mrs. Richards two of her daughters, Mrs. MACKENZIE and Mrs. LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs. MACKENZIE contacted Gosport police on 27th September, 1998 and alleged that her mother had been unlawfully killed.

Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

The Reviewing CPS Lawyer determined that on the evidence available he did not consider a criminal prosecution to be justified.

Mrs. MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

The complaint made by Mrs. MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17th April 2000.

Professor Brian LIVESLEY an elected member of the academy of experts provided medical opinion through a report dated 9th November 2000 making the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs. Gladys RICHARDS in a manner as to cause her death."

- "Mr. Philip James BEED, Ms. Margaret COUCHMAN and Ms. Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs. RICHARDS was unlawfully killed."

A meeting took place on 19th June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs. RICHARDS had been unlawfully killed were flawed in respect of his analysis of the law. He was not entirely clear of the legal ingredients of gross negligence/manslaughter.

Professor LIVESLEY provided a second report dated 10th July, 2001 where he essentially underpinned his earlier findings commenting:-

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

In August 2001 the Crown Prosecution Service advised that there was insufficient evidence to provide a realistic prospect of a conviction against any person.

Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH as a result four more cases were randomly selected for review.

Expert opinions were sought of a further two medical professors FORD and MUNDY who were each provided with copies of the medical records of the four cases in addition to the medical records of Gladys RICHARDS.

The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as they were all of a similar nature to

the RICHARDS case and would therefore attract a similar response as the earlier advice from counsel. A decision was then made by the Police that there would be no further police investigations at that time.

Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement for appropriate action.

Intervening Developments between Second and Third Investigations

On 22nd October 2001 the Commission for Health Improvement (CHI) launched an investigation into the management provision and quality of health care for which Portsmouth Health Care (NHS) Trust was responsible at GWMH interviewing 59 staff in the process.

A report of the CHI investigation findings was published in May 2002 concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality patient care.

The CHI further reported that the Trust post investigation had adequate policies and guidelines in place that were being adhered to governing the prescription and administration of pain relieving medicines to older patients.

Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

On Monday 16th September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

The documents were copies of memos letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including :-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

Nurse TUBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19th September 2002 the following decisions being made:-

- Examine the new documentation and investigate the events of 1991.
- Review existing evidence and new material in order to identify any additional viable lines of enquiry.
- Submit the new material to experts and subsequently to CPS.
- Examine individual and corporate liability.

A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

On 23rd September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients that had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns (including the five original cases)

In addition Professor Richard BAKER during his statistical review of mortality rates at GWMH identified 16 cases which were of concern to him in respect of pain management.

14 further cases were raised for investigation through ongoing complaints by family members between 2002 and 2006.

A total of 92 cases were investigated by police during the third phase of the investigation.

A team of medical experts (key clinical team) were appointed to review the 92 cases completing this work between September 2003 and August 2006.

The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

The terms of reference for the team were to examine patient notes initially independently and to assess the quality of care provided to each patient according to the expert's professional discipline.

The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1- Optimal care.
Category 2- Sub optimal care.
Category 3- Negligent care.

The cases were screened in batches of twenty then following this process the experts met to discuss findings and reach a consensus score.

Each expert was briefed regarding the requirement to retain and preserve their notations and findings for possible disclosure to interested parties.

All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to further confirm the decision that there was no basis for further criminal investigation.

Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly were referred to the General Medical Council and Nursing and Midwifery Council for their information and attention.

Fourteen Category 3 cases were therefore referred for further investigation by police. Of the fourteen cases, four presented as matters that although potentially negligent in terms of standard of care were cases where the cause of death was assessed as entirely natural. Under these circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.

Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant Geriatrician Dr David BLACK who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.

Accordingly the four cases ...Were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR

The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is to day outside the bounds of acceptable clinical practice, and cause of death unclear.'

The investigation parameters included taking statements from all relevant healthcare staff involved in care of the patient, of family members and the commissioning of medical experts to provide opinion in terms of causation and standard of care.

The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were provided guidance from the Crown Prosecution Service to ensure that their statements addressed the relevant legal issues in terms of potential homicide.

The experts completed their statements following review of medical records, all witness statements and transcripts of interviews of Dr Reid and Dr Barton the

healthcare professionals in jeopardy. They were also provided with the relevant documents required to put the circumstances of care into 'time context' The reviews were conducted by the experts independently.

Supplementary expert medical evidence was obtained to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

A common denominator in respect of the ten cases was that the attending clinical assistant was Dr Jane BARTON who was responsible for the initial and continuing care of the patients including the prescription and administration of opiate and other drugs via syringe driver.

Dr BARTON was interviewed under caution in respect of the allegations.

The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.

During the second interview challenge phase (following provision of expert witness reports to the investigation team) Dr BARTON exercised her right of silence refusing to answer any questions.

Consultant Dr Richard REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by expert witnesses. Dr REID answered all questions put.

Full files of evidence were incrementally submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.

- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

Additional evidence was forwarded to the CPS through the compilation of generic healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

The ten category three cases were:-

1. Elsie DEVINE 88yrs. Admitted to GWMH 21st October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21st November 1999, 32 days after admission cause of death recorded as Bronchopnuemonia and Glomerulonephritis.

2. Elsie LAVENDER 83yrs. Admitted to GWMH 22nd February 1996 with head injury /brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6th March 1996, 14 days after admission cause of death recorded as Cerebrovascular accident.

3. Sheila GREGORY 91yrs. Admitted to GWMH 3rd September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22nd November 1999, 81 days after admission cause of death Bronchopnuemonia.

4. Robert WILSON. 74 yrs. Admitted to GWMH 14th October 1998 with fractured left humerus and alcoholic hepatitis. Died 18th October 1998 4 days after admission cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26th March 1999 with a fractured neck of the femur. Died 13th April 1999 18 days after admission cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18th August 1998 with a fractured neck of the femur, diarrhea atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21st August 1998 3 days after admission cause of death recorded as bronchopneumonia.

7. Leslie PITTOCK 82 yrs. Admitted to GWMH 5th January 1996 with Parkinsons disease he was physically and mentally frail immobile suffering depression. Died 24th January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3rd June 1997 with many medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5th June 1997 2 days after admission cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66yrs. Admitted to GWMH 23rd August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3rd September 1999 13 days after admission cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21st September 1998 with Parkinson's disease and dementia. Died 26th September 1998 5 days after admission cause of death recorded as bronchopneumonia.

Dr David WILCOCK provided extensive evidence in respect of patient care concluding with particular themes 'of concern' in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues Including:-*

  Enid Spurgin – orthopaedic surgeon, microbiologist
  Geoffrey Packman – general physician, gastroenterologist
  Helena Service – general physician, cardiologist
  Elsie Lavender – haematologist
  Sheila Gregory – psychogeriatrician
  Leslie Pittock – general physician/palliative care physician
  Arthur Cunningham – palliative care physician.

Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK and other experts commissioned, the full details being contained within their reports.

There was however little consensus between the two principal experts Drs BLACK and WILCOCK as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death.

As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to overall expert evidence it could not be proved that Doctors were negligent to criminal standard.

Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.

Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction.

Family group members of the deceased and stakeholders were informed of the decision in December 2006 and the police investigation other than referral of case papers to interested parties and general administration was closed.

David WILLIAMS.

Detective Superintendent 7227

Senior Investigating Officer.

16th January 2007.

OPERATION ROCHESTER
GENERIC CASE SUMMARY

Further to the individual case summaries and files prepared for the individual patients. A further file of evidence has been prepared that should be read as an over view regarding events at the Gosport War Memorial Hospital from 1990 to 2002. Although this file alone does not pertain to any criminal charges it does corroborate all of the individual case files and should be read in conjunction with them.

The main points covered are as follows:-

1. Working Practices at the Gosport War Memorial Hospital

   Irene DORRINGTON is an experienced retired Staff Nurse who joined Northcotte Annexe in 1972, she moved to Redcliffe Annexe and then to Dryad Ward in 1994, she details the general running of the hospital and the changing needs of the patients throughout the years.

2. Concerns raised by the nursing staff in 1991 regarding the excessive use of diamorphine via syringe drivers on Dryad Ward and the resultant management action.

   In 1991 a number of night nursing staff including GRIFFIN, TURBRITT and TURNBALL had serious concerns about the use of syringe drivers on the ward. These concerns included:-

   - Patients placed on syringe drivers when not in pain.
   - The blanket use of syringe drivers before any other analgesics were tried.
   - The blanket prescribing of diamorphine prior to the patient actually requiring a strong opiod, allowing the nursing staff to commence the use of the driver without the knowledge of the Doctor.
   - Used to calm patients who were aggressive or noisy rather than for pain management.
   - Patient deaths were sometimes hastened unnecessarily.
   - The use of the syringe driver or commencing diamorphine prohibits trained staff from adjusting dose to suit the patient needs.
   - That too high a degree of unresponsiveness from patients was sought at times.
   - That sedative drugs such as thioridazine would sometimes be more appropriate.
   - That diamorphine was prescribed prior to such procedures such as catheterisation where diazepam would be just as effective.

- That not all staff views were considered before a decision was made to start patients on diamorphine.
- That other similar units did not use diamorphine as extensively.

These concerns were aired in a meeting held at Redcliffe Annexe on 11th July 1991 that had been arranged in conjunction with the patient care manager Isobel EVANS who addressed the concerns. A number of meetings then took place between nursing, medical and management staff. This resulted in the training of staff in the use of syringe drivers and pain control and an agreement that a policy be written by management on the use of syringe drivers and controlled drugs.

Keith MURRAY a Convenor for the Royal College of Nursing states that: Training was provided for staff by a Mr Steve KING probably, but a policy was never written. Murray's correspondences with regard to these meetings are available identification numbers KPM/1 to KPM/7.

The training did not allay the nursing staff fears and when TURBRITT attended a course in Elderly care at the Queen Alexandra Hospital she chose to speak on 'The use and abuse of the syringe driver'. Her course tutor Geri WHITNEY visited Radcliffe Annexe and met nursing staff on 31st October 1991 after a request by TURBITT. The main conclusion of WHITNEY'S visit was that:-

* The staff are concerned that non opiods or weak opiods were not being considered prior to the use of diamorphine.

* The staff have had some training arranged by the Hospital manager namely

  - the syringe driver and pain control
  - pain control

* Staff Nurse TURBRITT wrote to EVANS, the producers of diamorphine and reviewed literature and a video – Making Pain Management More Effective.

* Staff Nurse TURBRITT is undertaking a literature on Pain and Pain Control.

A copy of WHITNEY'S report was sent to both Mr W HOOPER (deceased) the General Manager, Gosport War Memorial Hospital, Mrs J EVANS the Patient Care Manager, and Susan FROST, Solent School of Health Studies, Principal her CV is available SAF/VC/1).

As a result of this Mrs EVANS circulated a memorandum on 7th November, asking for staff to identify any patient that they felt diamorphine (or any other drug) had been prescribed inappropriately. Due to the memo which mentioned 'allegations' and asking for individual responses to be put in writing Keith MURRAY sought the assistance of the Wessex Regional Office of the Royal

College of Nursing. This prompted a Steve BARNES to write to Mrs EVANS outlining the nurses' position. In the main after the meeting in July it was decided that:-

1. The concerns would be addressed.

2. Clear guidance/policy would be promulgated.

It had now become a matter of serious concern that:-

1. The complaints were not acted upon.

2. The management were now seeking formal allegations.

At this time the RCN stated that the RCN would not be 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 repeated to management and that if a policy was not formulated out then action would be taken by way of the grievance procedure.

A further meeting was then held at Radcliffe Annexe on 17th December 1991 with Medical, Nursing Staff and Mrs EVANS. This meeting is described as a 'them and us' meeting, medical staff on one side sat like a panel. During the meeting Mrs EVANS highlighted the action management had taken:-

(i) The staff meeting on 11th July.
(ii) Steve KING lecture on drug control.
(iii) Staff being invited to detail individual cases, none were forthcoming.
(iv) The stressed placed on medical staff and the issue being detrimental to patient care.

She also presented the staff concerns and a Dr LOGAN spoke regarding symptom control.

It was agreed that if any of the nursing staff had concerns in the future they would approach Dr BARTON or Sister HAMBLIN in the first instance and if not resolved they could speak to Dr LOGAN.

The medical staff then left the meeting and Mrs EVANS asked if there was still a need for a policy relating to nursing practice on the issue. No one at this meeting thought it was appropriate. Mrs EVANS then addressed staff stating she was concerned over the manner in which these concerns had been raised, as it had made people feel very threatened and defensive. It is clear that the concerns had been turned around the result being that the syringe drivers were not an issue recognised by the management, but the nursing staff who had raised the concerns and the way the concerns were raised were. As such the nursing staff felt vulnerable and unsupported to such an extent that they stopped complaining.

Due to the fact that the RCN took its lead from the nursing staff and as they did not hear anything further from them they also took the matter no further.

3. The Recovery of Letters and Meeting Minutes regarding the Events in 1991.

On Monday 16th September 2002 in order to inform staff that Professor BAKER had been tasked with reviewing the Gosport War Memorial Hospital and the prescribing procedures and policy's a meeting was called with the nursing staff. Prior to the meeting TURNBALL and TURBRITT approached Toni SCAMMELL a nursing manager at GWMH and handed to her a file containing letters and the minutes of the meetings held in 1991, these were subsequently handed to Jane Parvin and are available (JEP/GWMH/1/). These papers detailed the nursing staff concerns and management action. When asked why they had brought the documents forward now TURBRITT stated that she had seen an article in the Sunday newspaper about the GWMH which stated that no one had ever brought the concerns about syringe drivers to the attention of management before and that there had been no training in their use, but she had received training. When asked whether they felt the matter had been solved, as the documents seemed to stop abruptly, TURBRITT said that things had changed for a short period of time as patients didn't appear to be automatically put on diamorphine and that Dr BARTON had been on a palliative care course and knew what she was talking about. The replies were recorded (TJS/1). A further meeting was held on the 18th September 2002 to investigate the events of 1991 with TURBRITT, TURNBALL, SCAMMELL, Jane PARVIN (Personnel Director) and Betty WOODLAND (RCN Representative) being present. Notes from this meeting (TJS/2) reflect how TURNBALL & TURBRITT felt in 1991 throughout the different meetings and why they decided to speak to SCAMMELL now.

GIFFIN also kept the minutes of the 1991 meetings and letters relating to the concerns (SG/GWMH/1). Beverley TURNBALL identifies her letters from the bundle JEP/GWMH/1 and these are available JEP/GWMH/1/BAT/1.

Jan PEACH corroborates the meetings of the 16th and 18th September 2002 and provides continuity of the Exhibit JEP/GWMH/1. Kathryn ROWLES and Sue GAWLEY also provide corroboration to the events of the 16th September 2002.

The concerns of TURNBALL and TURBRITT and GIFFIN although not shared by all of the staff on Dryad Ward are corroborated by PARTRIDGE and GOLDSMITH. Betty WOODWARD is a RCN Steward and represented TURNBALL and TURBRITT at the meeting on 18th September and she provides a note of the invitation to the meeting (BW/1), notes of the meeting (BW/2) (Typed BW/3). A list of the documents in JEP/GWMH/1 (BW/4).

4. Concerns held by training nursing staff at Gosport War Memorial Hospital relating to diamorphine, syringe drivers and general patient care that were never aired with the management.

A number of nursing staff have subsequently been interviewed and have highlighted concerns that had never been mentioned before these include:-

Enrolled Nurse Code A – syringe drivers were used too often. Rather than being used to control pain they were used on patients who were approaching death and suffering anxiety and distress. Code A prescribed the diamorphine but it was up to a senior nurse when to use it. It was apparent that an awful lot of patients that died were on syringe drivers.

Code A – shared concerns of the nurses in 1991 and felt optimistic that the issues would be addressed. Left a couple of weeks after the meeting in July 1991 so didn't see how the issues were dealt with or what guidelines were put in place.

Code A – worked on Sultan Ward although covered other wards so is able to compare working practices between the different wards. In Daedalus ward the doses of diamorphine prescribed were set between large parameters leaving the dose administered to be decided by the attending nurse.

Code A – the needs and demands of the patients changed, by taking more acute patients. Medical cover was not reflected in the changes. Work load increased and patient contact was often less. By 2003 there was a lack of leadership and structure.

By charting a variable dose of medication the responsibility of the dose administered falls to the qualified nurse.

E Grade Nurse – Code A would prescribe diamorphine by phone but not conduct a follow up visit. Inappropriate prescribing of diamorphine i.e when a patient was not in pain and/or other analgesics not used prior. 'It seemed that people were going onto syringe drivers for no reason at all. They were not ill or in pain and yet they were dying shortly after going on the drivers'.

Recalls a patient Code A that was prescribed diamorphine.

Code A – Corroborates the statement of Code A regarding Code A States that Code A would mention diamorphine and the patient would be dead within the week.

Staff Nurse Grade F Code A – acknowledges that some staff had concerns with regard to the use of syringe drivers but did not have any herself. Attended the staff and management meetings, in 1991 regarding the staff concerns.

Staff Nurse Code A – on a couple of occasions a patient was put onto a syringe driver with diamorphine when there was no indication that they needed it. Attended the 1991 meeting but nothing changed as a result of it.

Staff Nurse Grade F Code A – syringe drivers were used too early before other methods of pain control had been tried, they were prescribed by Code A on the admission of the patient as, as and when

required prescription. Doses of diamorphine and midazolam were too high.

Code A actions were ill thought out and could have led to the premature death of a patient. I Code A discussed her concerns with Code A Code A who recorded these concerns in her diary of 2001 (JMI/1) and 2002 (JMI/2)

Grade F Staff Nurse Code A – had concerns over the high dosages of diamorphine given to patients. Drugs including diamorphine and midazolam were prescribed to patient on their arrival. It therefore became a decision for the nurses when to administer it. Patients went onto morphine without starting at the bottom of the analgesic ladder.

5. Concerns of Untrained Staff at Gosport War Memorial Hospital

Code A – holds concerns about the indiscriminate use of syringe driver. It appeared that euthanasia was practised. All patients upon their admission were written up by Code A who authorised the use of a syringe driver if appropriate, and that any person put onto a driver would die shortly afterwards.

Code A – believed that syringe drivers were used too soon on some patients. Patients were put on them because they just moaned and groaned. Patients put on a syringe driver would go into a coma and die a day or two week later.

Code A – untrained nurse would double check medication with a trained nurse if no other trained nurse was available and give patients medication that had been checked and left out by trained nurses when there wasn't any trained nurses on. Didn't understand why some stroke patients who didn't appear to be in pain were put on syringe drivers. When patients were put on syringe drivers they were not taken off of them until they died. In her opinion the use of a syringe driver shortened the patient's life. Diamorphine was used inappropriately, it made the patient quiet and shortened their life. It was given to patients who didn't require that level of pain relief. Diamorphine was used to keep the patients moving through the Annexe to keep waiting lists down. Code A didn't spend much time with the patients.

Code A – on occasions would leave work and a patient would appear to be well. On her return they would be receiving diamorphine through a syringe driver.

Code A – patients were placed on syringe drivers very early in their treatment. Other types of pain relief were not tried first.

Code A – syringe drivers used prematurely.

Code A – wondered why patients were on syringe

drivers.

RGN Grade D Code A – concerns re the lack of labels on drugs, or what was in the syringe driver.

Nursing Auxiliary Code A – untrained nurse who would countersign a withdrawal of diamorphine as a witness and was asked to countersign a withdrawal when she hadn't witnessed it.

RGN Staff Nurse Code A – there was a practice of pre-prescribing syringe drivers and diamorphine. This was a practice that was not used on other wards.

RGN Code A – worked on Daedalus ward in 1999 – 2000. States that the nursing care provided was very poor due to the poor management of the ward. Pain management was inadequate. No consideration was given to opiod tolerance. Correspondence outlining her concerns are available MRP/1 to MRP/3.

Staff Nurse Code A – there was a culture within Gosport that would not change, there was little support from Doctors and Management. Had to request his own training for syringe drivers.

RGN Sister Code A – describes how and why it was decided by Code A Code A and herself to prescribe medication prior to it being required.

6. Technical Matters, Production of Medical Records and Exhibit Continuity

Code A – provides details as to what Nozinam is used for, its properties, recommended dosages, when caution should be exercised prior to prescribing, and side effects.

Code A – produces the medical records of:-

Code A

- BJC/16
- BJC/30
- BJC/15
- BJC/21
- BJC/55
- BJC/45
- BJC/72
- BJC/67
- BJC/71

showing the deceased's treatment at Gosport War Memorial Hospital and Queen Alexandra Hospital and the admission books relating to Gosport War Memorial Hospital.

Dryad Ward 93/96 BJC/88
Dryad Ward 79/03 BJC/89
Daedalus Ward 01/03 BJC/90
Code A provides continuity for these exhibits and also produces cremation certificates for Code A (PJR/CREM/2) that show that both patients were in a coma prior to death.

Seven of the deceased were treated in Halslar Hospital (Military Hospital) prior to their admission to GWMH and their medical records are produced by Code A

Code A

- JR/11A (Chest X-rays JR/XR/1)
- JR/12
- JR/13
- JR/14
- JR/15
- JR/16
- JR/19A

The GP medical records for each of the patients are produced by Code A Code A as follows:-

Code A

- TAS/1
- TAS/2
- TAS/3
- TAS/4
- TAS/5
- TAS/7
- TAS/8
- TAS/9
- TAS/10

The controlled drugs record books for Gosport War Memorial Hospital, Sultan Ward, Dryad Ward, Daedalus Ward, Redcliffe Annexe, the female ward are produced by Code A and run from JP/CDRB/1 to JP/CDRB/48. Dryad Ward controlled drugs record books are available and cover the following periods,

25/06/95 to 24/05/96 – JP/CDRB/20
06/03/05 to 08/12/96 – JP/CDRB/21
22/11/96 to 23/06/97 – JP/CDRB/22
08/12/96 to 22/12/97 – JP/CDRB/23
02/09/98 to 18/06/99 - JP/CDRB/47
18/06/99 to 04/07/01 - JP/CDRB/48
12/07/97 to 05/03/02 – JP/CDRB/24

The bed numbers register from November 1992 t January 1997; JP/BNR/1 is also produced and covers Sultan, Dryad and Daedalus wards.

Code A the Pharmacy Services Manager for Portsmouth Hospitals NHS Trust explains how medicines are ordered, supplied and recorded and produces a hand book covering Palliative Care which gives guidance on Clinical management of patients who are dying (JJW/7). This includes, pain, diagnosis, strong opiods and syringe drivers.
Code A produces a fax copy headed 'Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion' ID/F & GPCT/1 that was sent to her by Code A (Medical Director PHCT) Secretary. This would appear to be the earliest protocol or policy regarding the prescribing of diamorphine by syringe drivers issued by PHCT and can be dated around the end of 1999. Even at this time it can be seen by this draft protocol the confusion surrounding the prescribing of diamorphine as it states:-

Dosage

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'X mg' of diamorphine then up to double the dose should be administered the following day, ie up to 2x 'X mg' should be given.

Prescription

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days,

Although these entries have been corrected to show the correct prescribing regime it clearly demonstrates the lack of knowledge and understanding by the hospital staff.

This is further highlighted by the patient care manager Code A who was responsible for all nursing care within the hospital who states incorrectly that if a patient was getting 10mgs of diamorphine orally every four hours amounting to 60 mgs over a 24 hour period then they would receive 60 mgs sub cut via the syringe driver over a 24 hour period.
The dose should be reduced by 1:3 or 1:2

Code A a GP in Petersfield describes the procedure for certifying cause of death within the PHCT and Code A explains the procedure at Gosport War Memorial Hospital producing an administrative form JAS/1 showing the administrative procedure followed in the hospital. Guidance of notice for the completion of cause of death certificates and a certificate JAS/2. Once the certificate is completed by the Doctor certifying death the certificate is placed in an envelope (JAS/3) which is sealed and taken by the deceased's relative or representative to the registrar. If the deceased is to be cremated further forms BC & F (JAS/4) are also completed. She also

produces the Cause of Death Certificate book with the relevant stub for each of the deceased:-

Code A - JAS/CODC/1
- JAS/CODC/2
- JAS/CODC/4
- JAS/CODC/6
- JAS/CODC/9
- JAS/CODC/10
- JAS/CODC/11
- JAS/CODC/13
- JAS/CODC/14

A certified copy of the deceased's death certificate is available produced by Code A :-

Code A - DB/2001
- DB/2002
- DB/2005
- DB/2007
- DB/2010
- DB/2011
- DB/2012
- DB/2014
- DB/2015

Code A a personnel assistant employed by Fareham and Gosport Primary Care Trust produces the job description for the Clinical Assistant at Gosport War Memorial Hospital that would have been applicable to Code A Code A (WJ/CA/1). This outlines the job summary as,

This is a new post of 5 Sessions a week worked flexibly to provide a 24hour Medical Cover to the Long Stay patients in Gosport. The patients are slow stream or slow stream rehabilitation, but holiday relief and shared care patients are admitted. An important aspect of this role is for the postholder to be seen not only as a medical advisor but as a friend and counsellor to patient's, relatives and staff.

Duties include, (This is not the entire list)

1. To visit the units on a regular basis and to be available "On Call" as necessary.
2. To ensure that all new patients are seen promptly after admission.
3. To be responsible for the day to day Medical Management of the patients.
4. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date and reviewed regularly.
5. To complete upon discharge the Discharge summary and HRM60.
6. To take part in the weekly consultant rounds.

7. Other Witnesses

On 4th April 2000 a Code A, 76 years of age was admitted to Haslar Hospital due to pain from arthritis and gout. As his condition was not acute he was discharged to Sultan Ward at The Gosport War Memorial Hospital for rehabilitation. Once there he was prescribed morphine sulphate tablets, a strong opiod for his pain. He became dozy suffering hallucinations and eventually slipped into unconsciousness. He was transferred back to the Haslar Hospital and diagnosed as having been given an analgesic over dose. Code A has a very poor memory of the whole episode. Code A Code A recalls the events. (Further work will be required around this part of evidence).

In 2002 the Chief Medical Officer commissioned Code A to conduct a statistical analysis of the mortality rates at the Gosport War Memorial Hospital, including an audit and review of the use of opiate drugs. His CV (RHB/CV/1) outlines his qualifications and experience. The report itself RHB/GWMH/1 concludes that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that small number of these would otherwise have been eventually discharged from hospital alive.

The practice was disclosed in several key findings.

Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver.

Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia and strokes.

Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later.

In many records, evidence of a careful assessment before use of opiates was absent, and the stepped approach to management of pain in palliative care had not been followed.

In addition to these findings, two other matters also gave rise to concern. The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths, most commonly fractured hips, had not been reported on MCCDs.

MG 9

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URN:

WITNESS LIST

Date of completion:

✱ Tick if statement attached

◆ Previous convictions? Enter Y or N

R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
1	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
2	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
3	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
4	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: Code A E-mail address:			
5	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE E GRADE Date of Birth: Code A Telephone: HOME Code A WORK Code A E-mail address:			

MG 9

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* Tick if statement attached

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	*	◆
6	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE F GRADE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
7	Name: Code A Address (HOME): Code A Occupation: RETIRED PATIENT CARE MANAGER Date of Birth: Code A Telephone: HOME Code A E-mail address:			
8	Name: Code A Address (HOME): Code A Occupation: RCN CONVENOR Date of Birth: Code A Telephone: WORK E-mail address:			
9	Name: Code A Address (HOME): Code A Occupation: RISK SERVICES MANAGER Date of Birth: Code A Telephone: HOME Code A E-mail address:			
10	Name: Code A Address (HOME): Code A Occupation: FULL TIME RCN OFFICER Date of Birth: Code A Telephone: HOME Code A E-mail address:			

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✷	◆
11	Name: Code A Address (HOME): Code A Occupation: DEAN OF SCHOOL OF HUMAN AND HEALTH SCIENCES Date of Birth: Telephone: HOME Code A E-mail address:			
12	Name: Code A Address (HOME): Code A Occupation: RCN OFFICER Date of Birth: Telephone: HOME Code A WORK Code A E-mail address:			
13	Name: Code A Address (HOME): Code A Occupation: SENIOR NURSE Date of Birth: Telephone: HOME Code A WORK Code A E-mail address:			
14	Name: Code A Address (HOME): Code A Occupation: HOSPITAL SERVICE MANAGER Date of Birth: Telephone: HOME Code A WORK Code A E-mail address:			
15	Name: Code A Address (HOME): Code A Occupation: PERSONNEL DIRECTOR Date of Birth: Telephone: HOME Code A WORK Code A E-mail address:			

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'Y' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
16	Name: Code A Address (HOME): Code A Occupation: DIRECTOR OF PUBLIC HEALTH Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
17	Name: Code A Address (HOME): Code A Occupation: COMMUNICATIONS MANAGER Date of Birth: Code A Telephone: WORK E-mail address:			
18	Name: Code A Address (HOME): Code A Occupation: RISK ADVISER AND FACILITATOR Date of Birth: Code A Telephone: HOME Code A E-mail address:			
19	Name: Code A Address (HOME): Code A Occupation: STATE ENROLLED NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
20	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
21	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
22	Name: Code A Address (HOME): Code A Occupation: COMMUNITY STAFF NURSE Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
23	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
24	Name: Code A Address (HOME): Code A Occupation: STUDENT Date of Birth: Code A Telephone: E-mail address:			
25	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE F GRADE Date of Birth: Code A Telephone: E-mail address:			

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Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
26	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
27	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Telephone: HOME Code A WORK Code A E-mail address:			
28	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
29	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
30	Name: Code A Address (HOME): Code A Occupation: PROVIDENT AGENT Date of Birth: Telephone: HOME Code A WORK Code A E-mail address:			

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✷	◆
31	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Telephone: HOME Code A E-mail address:			
32	Name: Code A Address (HOME): Code A Occupation: LEARNING SUPPORT ASSISTANT Date of Birth: Telephone: HOME Code A E-mail address:			
33	Name: Code A Address (HOME): Code A Occupation: WARD CLERK Date of Birth: Code A Telephone: HOME Code A E-mail address:			
34	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Telephone: HOME Code A E-mail address:			
35	Name: Code A Address (HOME): Code A Occupation: EX NURSING AUXILIARY Date of Birth: Code A Telephone: HOME Code A E-mail address:			

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36	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
37	Name: Code A Address (HOME): Code A Occupation: REGISTERED GENERAL NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
38	Name: Code A Address (HOME): Code A Occupation: PHYSIO TECHNICIAN Date of Birth: Code A Telephone: HOME Code A E-mail address:			
39	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: E-mail address:			
40	Name: Code A Address (HOME): Code A Occupation: MEDICALLY RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			

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R v

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41	Name: Code A Address (HOME): Code A Occupation: STAFF NURSE Date of Birth: Code A Telephone: HOME Code A E-mail address:			
42	Name: Code A Address (HOME): Code A Occupation: RETIRED RGN Date of Birth: Code A Telephone: HOME Code A E-mail address:			
43	Name: Code A Address (HOME): Code A Occupation: MEDICINES / PHARMASIST INFORMATION MANAGER Date of Birth: Code A Telephone: MOBILE Code A WORK E-mail address:			
44	Name: Code A Address (HOME): Code A Occupation: OUTPATIENT SERVICES MANAGER Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
45	Name: Code A Address (HOME): Code A Occupation: CIVIL SERVANT Date of Birth: Telephone: HOME Code A WORK Code A E-mail address:			

MG 9

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
46	Name: Address (): Occupation: Telephone: E-mail address: **Code A**			
47	Name: Address (): Occupation: Telephone: E-mail address: **Code A**			
48	Name: **Code A** Address (WORK): **Code A** Occupation: ACCESS TO MEDICAL RECORDS COORDINATOR Date of Birth: **Code A** Telephone: WORK E-mail address:			
49	Name: **Code A** Address (HOME): **Code A** Occupation: PHARMACY SERVICES MANAGER Date of Birth: **Code A** Telephone: HOME **Code A** WORK E-mail address:			
50	Name: **Code A** Address (HOME): **Code A** Occupation: PERSONNEL ASSISTANT Date of Birth: **Code A** Telephone: HOME **Code A** WORK E-mail address:			

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✸	◆
51	Name: Code A Address (HOME): Code A Occupation: SECRETARY Date of Birth: Code A Telephone: HOME Code A E-mail address:			
52	Name: Code A Address (HOME): Code A Occupation: GENERAL PRACTITIONER SELF EMPLOYED Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
53	Name: Code A Address (HOME): Code A Occupation: PATIENTS AFFAIRS OFFICER Date of Birth: Code A Telephone: HOME Code A WORK E-mail address:			
54	Name: Code A Address (WORK): Code A Occupation: CIVIL SERVANT Date of Birth: Telephone: E-mail address:			
55	Name: Code A Address (): Occupation: SECRETARY TO PERSONNEL DIRECTOR Date of Birth: Code A Telephone: WORK E-mail address:			

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✱	◆
56	Name: Code A Address (HOME): Code A Occupation: RETIRED ELECTRICAL MANAGER Date of Birth: Code A Telephone: HOME Code A E-mail address:			
57	Name: Code A Address (HOME): Code A Occupation: RETIRED Date of Birth: Code A Telephone: HOME Code A E-mail address:			
58	Name: Address (WO Code A Occupation: DIRECTOR AND PROFESSOR OF QUALITY IN HEALTH CARE Date of Birth: Code A Telephone: Code A E-mail address:			
59	Name: Address (): Occupation: Code A Telephone: E-mail address:			

MG 9

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R v

Wit No	Witness Details (In the 'Wit.No.' column enter 'V' if the witness is a victim, 'Vu' if vulnerable or intimidated)	Statement Number	✷	◆
60	Name: **Code A** Address (): Occupation: Date of Birth: Telephone: E-mail address:			

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Court Print Index (Sequential)

Court Print Index

Code A

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	RETIRED NURSE	S6A	6- 9
	RETIRED	S190	10- 11
	RETIRED	S32	12- 14
	STAFF NURSE	S26	15- 21
	NURSE	S33	22- 27
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	RCN CONVENOR	S38	32- 38
	RISK SERVICES MANAGER	S27	39- 40
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EXHIBIT LIST

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R v

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
COPY OF DRAFT LETTER WITH ACCOMPANYING LETTER 15/2/91 TO Code A Code A	KPM/1	Person Producing Current Location:	
COPY OF DRAFT LETTER DATE 28/02/1991 FROM Code A TO Code A	KPM/2	Person Producing Current Location:	
COPY OF DRAFT LETTER 4/3/91 TO Code A FROM Code A	KPM/3	Person Producing Current Location:	
COPY OF HANDWRITTEN LETTER DATED 5/3/91 TO Code A FROM Code A Code A	KPM/4	Person Producing Current Location:	
COPY OF LETTER DATE 30/4/91 FROM Code A IN FORM OF STEWARD NOTICE	KPM/5	Person Producing Current Location:	
COPY OF LETTER DATED 30/04/91 TO Code A FROM Code A	KPM/6	Person Producing Current Location:	
COPY OF LETTER DATED 14/11/91 TO Code A FROM Code A	KPM/7	Person Producing Current Location:	
CV Code A	SAF/VC/1	Person Producing Current Location:	

Code A

Date of completion:

RESTRICTED

MG 12

EXHIBIT LIST

URN:

R v

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
RED PLASTIC DOCUMENT HOLDER CONT CORRES RELATING GWMH DATED 11/1/92	JEP/GWMH/1	Person Producing Current Location:	
RECORD OF MEETING WITH Code A AND Code A 1300 HRS 16/9/02	TJS/1	Person Producing Current Location:	
MINUTES OF MEETING 18/9/02	TJS/2	Person Producing Current Location:	
LETTERS AND MINUTES OF MEETINGS REGARDING REDCLYFFE ANNEX	SG/GWMH/1	Person Producing Current Location:	
CLEAR PLASTIC WALLET CONT CORR RE TO GWMH 11/1/92 ADD Code A	JEP/GWMH/1/BAT	Person Producing Current Location:	
CONTROLLED DRUGS RECORD BOOK 25/6/95 - 24/5/96	JP/CDRB/20	Person Producing Current Location:	
CONTROLLED DRUGS RECORD BOOK 6/3/95 - 8/12/96	JP/CDRB/21	Person Producing Current Location:	
CONTROLLED DRUGS RECORD BOOK 22/11/96 - 23/6/97	JP/CDRB/22	Person Producing Current Location:	

Code A

Date of completion:

RESTRICTED

MG 12

EXHIBIT LIST

URN:

R v _____

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
CONTROLLED DRUGS RECORD BOOK 8/12/96 - 22/12/97	JP/CDRB/23	Person Producing Current Location:	
WARD CONTROLLED DRUGS RECORD BOOK 2/9/98 - 18/6/99	JP/CDRB/47	Person Producing Current Location:	
WARD CONTROLLED DRUGS RECORD BOOK 18/6/99 - 4/7/01	JP/CDRB/48	Person Producing Current Location:	
CONTROLLED DRUGS RECORD BOOK 12/7/97 - 5/3/02	JP/CDRB/24	Person Producing Current Location:	
BED NUMBERS REGISTER NOV 1992 - JAN 1997	JP/BNR/1	Person Producing Current Location:	
NOTES MADE OF CONVERSATION WITH Code A	BW/1	Person Producing Current Location:	
ROUGH NOTES MADE AT MEETING 18/9/02 GWMH	BW/2	Person Producing Current Location:	
TYPED NOTES OF MEETING 18/09/02	BW/3	Person Producing Current Location:	

Code A

Date of completion:

RESTRICTED

MG 12

EXHIBIT LIST

URN:

R v

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
HANDWRITTEN LIST OF DOCUMENTS GIVEN BY Code A TO Code A Code A	BW/4	Person Producing Current Location:	
DIARY 2001 OF Code A Code A	JMI/1	Person Producing Current Location:	
DIARY 2002 OF Code A Code A	JMI/2	Person Producing Current Location:	
LETTER TO Code A DATED 8/5/00	MRP/1	Person Producing Current Location:	
MEMO TO Code A DATED 14/5/00	MRP/2	Person Producing Current Location:	
HANDWRITTEN ROUGH LETTER TO Code A	MRP/3	Person Producing Current Location:	
MEDICAL RECORDS Code A	BJC/16	Person Producing Current Location:	
MEDICAL RECORDS Code A	BJC/30	Person Producing Current Location:	

Code A

Date of completion:

RESTRICTED

MG 12

EXHIBIT LIST

URN:

R v _____

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
MEDICAL RECORDS Code A	BJC/15	Person Producing Code A Current Location: FAREHAM MIR	
MEDICAL RECORDS Code A	BJC/21	Person Producing Code A Current Location: FAREHAM MIR	
MEDICAL RECORDS Code A	BJC/55	Person Producing Code A Current Location: FAREHAM MIR	
MEDICAL RECORDS Code A	BJC/45	Person Producing Code A Current Location: FAREHAM MIR	
MEDICAL RECORDS OF Code A	BJC/72	Person Producing Code A Current Location: FAREHAM MIR	
MEDICAL RECORDS OF Code A	BJC/67	Person Producing Code A Current Location:	
MEDICAL RECORDS OF Code A	BJC/71	Person Producing Code A Current Location:	
ADMISSION BOOK DRYAD WARD 93/96	BJC/88	Person Producing Code A Current Location:	

Date of completion:

RESTRICTED

MG 12

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URN:

R v _____

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
ADMISSION BOOK DRYAD WARD 97/03	BJC/89	Person Producing Current Location:	
ADMISSION BOOK DAEDALUS WARD 01/03	BJC/90	Person Producing Current Location:	
THIRTY-TWO CREMATION CERTIFICATES	PJR/CREM/2	Person Producing Current Location:	
MEDICAL RECORDS RELATING Code A Code A	JR/11A	Person Producing Current Location:	
Code A X RAYS	JR/XR/1	Person Producing Current Location:	
MEDICAL RECORDS Code A B. Code A	JR/12	Person Producing Current Location:	
MEDICAL RECORDS Code A	JR/13	Person Producing Current Location:	
MEDICAL RECORDS: Code A Code A	JR/14	Person Producing Current Location:	

Code A

Date of completion:

RESTRICTED

MG 12

EXHIBIT LIST

URN:

R v

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
MEDICAL RECORDS: Code A	JR/15	Person Producing Current Location:	
MEDICAL RECORDS: Code A	JR/16	Person Producing Current Location:	
MEDICAL RECORDS RELATING Code A	JR/19A	Person Producing Current Location:	
MEDICAL RECORDS Code A Code A	TAS/1	Person Producing Current Location:	
G P MEDICAL RECORDS Code A	TAS/2	Person Producing Current Location:	
G P MEDICAL RECORDS Code A	TAS/3	Person Producing Current Location:	
G P MEDICAL RECORDS Code A	TAS/4	Person Producing Current Location:	
G P MEDICAL RECORDS Code A	TAS/5	Person Producing Current Location:	

Code A

Date of completion:

RESTRICTED

MG 12

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URN:

R v

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
G P MEDICAL RECORDS Code A	TAS/7	Person Producing Code A Current Location:	
G P MEDICAL RECORDS Code A	TAS/8	Person Producing Code A Current Location:	
G P MEDICAL RECORDS Code A	TAS/9	Person Producing Code A Current Location:	
G P MEDICAL RECORDS Code A	TAS/10	Person Producing Code A Current Location:	
HANDBOOK COVERING PALLATIVE CARE	JJW/7	Person Producing Code A Current Location:	
COPY OF FAX HEADED PROTOCOL FOR PRESCRIPTION AND ADMINISTRATION	ID/FGPCT/1	Person Producing Code A Current Location:	
ADMINISTRATIVE PROCEDURE	JAS/1	Person Producing Code A Current Location:	
RELEVANT PAGES CERTIFICATION OF DEATH	JAS/2	Person Producing Code A Current Location:	

Date of completion:

RESTRICTED

MG 12

EXHIBIT LIST

URN:

R v

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
ENVELOPE	JAS/3	Person Producing Current Location:	
FORMS B,C, F.	JAS/4	Person Producing Current Location:	
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER 850788 Code A Code A	JAS/CODC/1	Person Producing Current Location:	
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER Code A Code A	JAS/CODC/2	Person Producing Current Location:	
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER Code A Code A	JAS/CODC/4	Person Producing Current Location:	
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER Code A Code A	JAS/CODC/6	Person Producing Current Location:	
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER Code A Code A	JAS/CODC/9	Person Producing Current Location:	
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER Code A Code A	JAS/CODC/10	Person Producing Current Location:	

Code A

Date of completion:

RESTRICTED

MG 12

EXHIBIT LIST

URN:

R v

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER Code A Code A	JAS/CODC/11	Person Producing Current Location:	
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER Code A Code A	JAS/CODC/13	Person Producing Current Location:	
STUB OF CAUSE OF DEATH CERTIFICATE NUMBER Code A Code A	JAS/CODC/14	Person Producing Current Location:	
CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2001	Person Producing Current Location:	
A CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2002	Person Producing Current Location:	
A CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2005	Person Producing Current Location:	
A CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2007	Person Producing Current Location:	
A CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2010	Person Producing Current Location:	

Code A

Date of completion:

RESTRICTED

MG 12

EXHIBIT LIST

URN:

R v _____

* Tick if exhibit attached

Description as per label (Indicate if copy)	Exhibit Ref. No.	Person producing and current location of exhibit	*
A CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2011	Person Producing Current Location:	
A CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2012	Person Producing Current Location:	
A CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2014	Person Producing Current Location:	
A CERTIFIED COPY OF A DEATH CERTIFICATE Code A	DB/2015	Person Producing Current Location:	
JOB DESCRIPTION FOR CLINACAL ASSISTANT AT G W M H	WJ/CA/1	Person Producing Current Location:	
CV OF Code A Code A	RHB/CV/1	Person Producing Current Location:	
REPORT OF Code A Code A RELATING TO THE GWMH	RHB/GWMH/1	Person Producing Current Location:	
ROOM 3 & 4 GOSPRT WAR MEMORIAL HOSPITAL (PHOTOGRAPHS)1145	VGR/1	Person Producing Current Location:	

Code A

Date of completion: