FFW/151/05.

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

Code A

Code A

WORKING FILE

Code A

1·5
3 listing

query

Code A

5/11/07 - 2.

" "

check.

check.

Code A

Code A

? (possibly **Code A** ?)

→ other picture of **Code A**
sister.

x call **Code A** prior to letter.

Send to Code A.
covering letter. —.
NOH —.

letter to relatives — copy of NOH →.
first day.

explain how proceeding wk.

- Not gen enq. Prosecution — ↓ allegations.
  crim standard.

↳. Code A

Code A — cud wit summons her.
only time GMC likely to have
Code A.

- Expl going to take pls.
  Happy to call.
  Need to know asap.

Burdoss - Need to agree with def →.

Code A - supplemental - call in anyevent.

Code A - read P S by agreement.

Disclose relyes - Re wit comment. →

15. Code A - Do we want him? If willing to assist pls do, resp - like to call him - if not review

16 Neil - Read if agreed.

17 Code A Doesn't want to assist.

18 - Not too pressure

19 - Code A - willing to read, if def agree.

20 Code A → Need her.

21. Code A →. speak to him, is needed → wS if required - Production S'ment.

 Code A

22. Code A - would like to read - (if can't find → third trust. maybe).

23 Code A.

24 Code A.

25. Code A - would like to read tetl def, production s'ment if can get if better.

26. Code A - Do want her, ↳ w/s if req.

27. Code A → if got Code A, don't need Code A. (Read if agreed with def.)

28 Code A. Need.

29 Code A Need.

30. Code A. } Need one or other.

31. Code A. }

Doctors:

A.
B.
C.
D.

Code A

E **Code A** – **Code A** to review →.

Police officer.

→ produce

Expert. raise 1st July appointment.
if not possible reading day.

Expert rep't. – put in before each pt evidence. – def objections? their expt rep't in.

week.
22/6/09.

Nurses.

① Code A - find Production s'ment.

② Code A Code A .

③ Code A - explore availability.

④ Code A - read query.

⑤ Code A . - check availability.

⑥ Code A y -.

⑦ Code A . - Not av.

⑧ Code A .

⑨ Code A .

⑩ Code A .

⑪ Code A .

12 Code A - Code A to co turn.

13 Code A .

Panel **Code A**

Code A - chronology.

- sending draft to counsel - Def. add to if req. - include **Code A**.

↳

sticking with existing pagination.

seek to agree with Def.

Rundless.

Box 1 - 4 no boxes 2 or 3.

5 - case summaries.

6 - items.

12 noon.

Production o'ments for.

Dr. Code A – find him.
" – find him.

Code A – Bahraine.

Code A – unrolling also BLT otter.
HD prod 6454364.

Dr Code A –

Dr Code A .

Code A – ~~difficult to trace~~.

Code A –

Agree o/side.

Bundloss.

Code A

Code A

RC / SME meeting.

① anonymisation.
Speak — M / W.
Children. - actual contact.

Public inq. — makes more sense.

② timing → re telling wit ford involved. - when?

③ **Code A** single expert looked at 12 cases for GMC, ID is matter for GMC — at this stage — not instructed to identify.

How can expert id ? assist re statement.

④ No of M - out to bits ? or first day.

Boxes - retrieve -

Unused disd.

useful stuff → operation Rochester.

Unused. — indexed originally.

28 boxes all in archives.

Def copy / counsel / original.

Code A

/46
n /28
/29
/8

Code A /12
16
14
11A
19A
2
5
3

JR/12

Code A /21 53
26 18
16 10
15 24
45 8A 70
30 11 66
71 91 4
67 44 40
72 60 27
41 32 23
35 80 42
27 25 12
49 61 3
44 31 9
51 57 54
54 17 36.

request out of archive.

↳ archiving No Code A →.

look at boxes.

Code A .

P S — Code A .

Code A

Code A kept 14 | 3 | 08.

① Code A issue. → fund drug increase. –

Tom req.

GMC amendments.

- **Code A**

r) } electronically

- copies of advices. } electronical

correspond - between parties.

discussions with

27/7/00 - Police informed Code A.
↳ investig on going

14/8/01 - Police tell GMC not taking GR further but addition concerns re other pts raised.

6/2/02 - Police tell GMC re other 4 pt - expt repts.

17/5/02 - Code A - letter to GMC.
28/6/02 - Code A (Code A step son) letter GMC
18/5/02 - Code A letter to GMC.

29/30/9/02 PPC → PPC.

June 2001. - Code A - GMC told Police NU.

Code A

Code A

Code A

ep 2

* Treatment approp (or Code A)

* - Poor treat but just about adequate.

Code A

- sub optimal (2) was originally at (3).

Code A

Code A

Generic Rapt ✓

A - 2V

B - mg.

C -

D - mg.

E -

F - mg.

G - mg

H - mg

I - mg.

J - mg.

K -

Code A

Code A - Code A

- 12 patient, list -

Gosport war Mem H. → Hampshire (Gosp) Portsmouth

o/D diamorphine -

Royal Haslar H - Navy H → discharged to GWMH. - for rehab.

Code A voting up s/drivers for as soon as pt arrived. - first thing in morning / night. - drug s/drivers/pres

GP - + working at GWMH part time. clinical assistant. (GP 10yrs).

happened 10 yrs ago.

Police - Code A ? →

→ Not convicted but (?) charged.

2 difficult wit - (Code A).

- Code A.

Wits for M. approx - 40 - 50.

M - London 8 June → Code A / Code A

↳ contact both.

Dr Code A → expert.

- Prof Code A - was prev expert

MDU — Code A.

Def Counsel (?). Code A ?

Inquests.

↳ Notes (AW's) -

- main issue Code A -
(main nurses - Code A point of contact - call re s/driver)
[redacted] deposition. - soon

wit statements → some (few) outstanding

M - pharmacist - Code A →
ignored all corresp. - "I can't be involved.

Dranatis / pas.

General view → took on too much → easiest way of dealing.

CMI rep't → critical of whole thing.

Dr Code A - not totally resp → Nursing staff (NMC holding off until GMC findings).

GMC's position - ? stuck off.

(*) Code A - s'ment. -

Bundle - med records - only in Hosp matter of days.

- Morphine O/D.

Issues.

Some pts had donatia - but families saying No.

Code A

Code A — Code A

Code A – toilet ↓.
(late ~~60~~60's).

other pt in 80/90's.

* 10P ↓ what current position.
– July 2008 – Notting prior.

- Press – inquest – until end of April.

10 of 12.

Code A – mum will have own inquest. – 2 days.

7 of 10 been cremated.

- No exhumed.

Expert Repts.
1 x generic.
12 x individual. } Black

Med records - Code A got (our only copy).

Generic - Stuff. - were police files,

coroners paper - prev disclosed.

ward maps. x 20.

Medical record - many pt not going ahead with

Disclosure - work thru letters.

Medical records - Say on Spine

files - named,

Police experts - Code A

(Code A). (Code A kept (?) came up at inquest but not done, Relatives think so - won't accept. this - ongoing saga.

witness statement - police statements problems - names wrong etc. production statement.

Code A

Dr Code A Consultants on ward -
woman
Dr Code A - joint pty in this ↔
wks in NZ.

Dr Code A

May only use Dr Code A becos Code A
Code A still friend

- Instructions to counsel - various matters.

controlled drugs register.

Not going ahead - **Code A**

- ** Expert Repts Code A .

* Storager room - 10P. papers
generic x extra
copies.

Code A

- Code A not coming –
- Need original Police rept Code A.
- What happening – inquest.
- Prof Code A rpts S + generic.
-

8/4/09.

Conference.

Code A.

Code A - confirms rept Code A* Spt.

Code A - others - 2 almost compl'd
all rept for easter Tuesday.
to Def by. 17/4/09.

ones sent drafts - yes. various
needed amendments -

How does Prof Code A want biding up -
FFLO? No happy to do himself.

Generic Rept.

→ TK questions. -

Page No.

(1) - any evidence syringedrivers not
differentiated in current case?
No - from BNF - pt of making this
need well trained staff + monitoring
of syringes. Doubt that we cud
be confident that drug error
picked up.

Training.

Dr Code A - trusted nurses, knew nuergine o/d. Well trained

Code A - If as dr - wide dose range, (ptnrs reluctant to come out + see pts when on call) - not acceptable, given high risk of drugs + need to reassess.
Dr Code A visiting 2x daily (5 days). and increase at each visit

cases show nursing staff failed to notice o/d levels + increases. Need to look at training

Use of opiates for insomnia or distress - unjustified! Expect nurse to get cool pot + calm her down. Then hypnotic then slightly stronger only opiate if pt assessed. Rob told ringing up ↑ prescriptions. ↳ anticipated

Dr Code A can't argue that nurses suitable experience

Need to give dosage small amount, see how pt is, if still problem inc 50% ~~of~~ response. Not many (4) accept this. v high dose range not acceptable up to 20mgs — reckless.

↳ para 13.

* Note 2. - check correct BNF 1995.

Note 3 Wessex Protocol — will this assist nurses — may take text into protocol used for prescribing opiates - Not sufficient to just use alone. Wessex P — primarily designed for non-palliative care specialist + palliative care teams.

↳ it's about palliative care not pain relief in older frail pt.

Dr [Code A] worked on basis of old pt ie in pain dying

Pathway "Palliative care" delirium
Pt have a condition, not curable
likely to lead to death within
months. can apply palliative care
measures to other pt in pain
but not palliate.

"Liverpool Care pathway" →
pt not dying. - can take pt
on + off the pathway. Time

If LCP Protocol followed, problem
do attempt to u/s the reason
for it and pain relief not palliative
care.

Wessex Protocol is Palliative care
handbook.

→ updated? Not sure but
Liverpool Care pathways.

We get Wessex Prot from HCC

* Note 4. para 26 — what training
GP need to do re geriatrics
↳ some may have but not all.
Some drs have experience
at SHO level or Geriatrics
diploma.

the group of pt at Gosport - No usual for GP experience. Dr Code A had lack of understand of geriatric care.

Dr Code A any on site training? Dr Code A + Code A ? No - could use in Dr Code A defence.
Wudn't need exp in geriatric medicine to get clinical assistance.
If trainee - then supervisor to monitor. But Dr Code A GP so not a training post. - claims so in one policy statement.

Dr Code A - whether exp or not - needs to comply GMP + BNF - If Dr Code A had written in notes looked bad to be ok re GMP.

BUPA exam

Assessments -

No records of assessment of pt - sometimes prescription by phone. problem?

Prof F - much more diffic to assess old people, so to hard to nurse + then prescribe opiates not acceptable.

Most continuing care - nurse care - don't need medical care, don't need palliative care - correct.

Note 5, para 27 – (H) had continuing nursing care for old people at same time acute med wards with old people coming in. Told was move to care homes. Pt mixed pt – continuing care – slowly deteriorate, med care – different to rehab pt. – reassess, medicate approp. 2 completely different cultures.

↳ Nurses won't clear which category pts in. Drs Code A + Code A – good assessments but ambiguous, Dr Code A did may not have made the distinction.

↳ Shud Dr Code A made better assessment?

↳ req on ref consultants says pts in med wards, plan not clear.

But in some cases Dr Code A stated treating by consultant WR, i.e. their plan was different.

Note 6. PRN - shud say what meds for — senna "for constipation" drs don't always do this.

Hyosc scripts for opiates didn't say what for.

Wud expect nurse to know opiates for severe pain. Wudn't put in script charts — but wud in notes — Dr [Code A] didn't put in either.

"Distress" not BNF recom / licence for opiate. (Midazolam — yes).

Consider — where ID error like "distress" occurred, shud this have alerted Dr [Code A] that scripting shud not continue / more careful.

"Distress" case — dr [Code A] wrote diazepam script following day — so Dr [Code A] picked up as a problem. In modern day hosp culture, CIF — but not culture in 1990's or in Gosport.

Criminal burden on his case,

Note 7. – "Vero" in 1990's hypnotic drugs were prescribed.

Anticipated prescribing not acceptable for opiate drugs. Not a phase used in 1990. Most drs take dum view anticip. prescribing.

Add appendix – each drug to be explained.

TK – suggest Dr Code A review – previous rept + ensure in line with new rept

Code A – not picked up wer probs in prev rept – Code A picked up. Not clearly recorded in narr (4) or there will add observation, change rept or opinion let us know

In previous rept to police looked at did dr Code A action lead to death? Not done so in those rept – criminal standard. – Now Bolt – wud say – hastened death – shud put in rept may not lead in evidence. but need to know Prof Code A view.

eg Code A — "very likely lead to death"

by Prof Code A difficulty re pt becos no monitoring records.

Code A explained — don't worry re legality but must explain.

Prof Code A Q — any other matters in generic rept.

- Nurse training
- Relationship - Nurses/drs.
- Could/ok to trust drs.

Code A (C).

Approach to be taken re drugs given ✓ ok.

para 9.

diamorphine. — will convert to morphine - good pract work out how much morphine had + give approp amount.

At para 9 - need to make clear that assume 6mgs x 2 diamorphine on 1/3/98

If someone is agressive + spitting out tabs possible to give patch. but must keep monitored.
↳ also no evidence that **Code A** in pain.

↳ timing removal of patch not clear, appears still on pt when diamorphine started.
↳ and midazolam.

↳ No evidence of pain ∴ wud give sedatives.

Pts do get agitated but this is a recognised side effect of morphine.

para 11 Hyoscine - anti cholinergic drug, to reduce secretions, comm dont ill pts. rattle/bubble.
↳ doesnt give unapprop effects to level of morphine but can cause confusion.

para 12. assessment - "failure" or "failure to note". -

If dr doesnt write down something etc diff to say didnt happen

Dr Code A cud say did assess EP just didnt write down.
Maybe shud say - no notes :.
no evidence that assessed

Allowing others to carry out - delegation.
GMP para in GR - 13/14

Dr Code A fitted in the clinical assistant before GP practice [wrch] after wk.
normal clinical assistance 9 - 12 session.

In 1990 - Drs struggled to deliver the responsibility had.

2002 - 2004 - changed substantially

Dr Code A said to Code A didnt have sufficient time

Code A . D .

Is failure to adequately assess her.

Prof **Code A** → need to know how strong Prof **Code A** is re whether assessment good. An eg if prescribed over phone then can't have assessed.

Prof **Code A** – no nursing notes say Pt recorded by Dr **Code A**

It is up to say that no notes i.e. not done. – not Dr **Code A** come back + defend.

Code A (F)

5.9 – "bubby" – becoe close to death? drugs make her less alert.

Chest pain / opiates – incorrect if cardiac pain why not do ECG – no record of BP – not acceptable.

If palliative care ward, could be an ~~not correct~~ continuing ECG machine available → one interviewer could ecg.

"Happy for nursing staff to confirm death"
↳ reasonable if known pt dying – v. poor med pract for elderly rehab pt (not acceptable) – Drs shld certify death.

"Not for resus" → "555" appeared to be interp as palliative care pt + Dr Code A debated accordingly

Para 9 – Code A – anxious/distressed – given morphine.
– say shld get with her.
↳ scale of other drugs.

* put in ref re agitation esp side effect to morphine.

Code A

↳ most shocking cases – bled to death.

GP had some bleeding at Q Mary Anne Hosp. Dr Code A good assessment.

moved to Dryad kept – blood in stools, didn't follow up blood tests.
internal bleeding.
Only thing wrong is pt overweight + leg swelling.

Dr Code A new near death but didn't change plan.

bleeding from ulceration

Note 3 – insert para re Code A prescribing.

555 – NF Rosus. – 1999 – not discussed with pts or relatives. – system changed after pts found out.
GP aware – not acceptable to say 555.

↳ no policy at (H) – Four to dr Code A

made prior to arrival to Dr Code A care.

all his health probs were treatable.

NB in Dyad ward no defib.

Code A I.

- para 3 12 - add'n incremental increase 4.

- Dr Code A reduced to 4 mgs - shud have stopped and then had naloxone. →

Also no (investig re surg gone wrong.

- Finished 8.15pm.

Inquest – A10 – Coroners assist – first read outs
jury out next wed.

transcript – sent out by transcribers
3 wks evidence.

likely to finish 2 – hoped get home by next Friday. 17/4/09.

called Code A (expt) called by coroner
took 2 days to give evidence
∴ go back to him 2.

add charges – refailure to assess?
need to know strength of prof ford.

one outstanding not so much of a problem.

family names given –

update letter to fams – post reg know whether / latter
work out at IO – comments using = name.

but families will need to u/stand pat records. will be aired publically

Code A needs a list.

Nurses – gave evidence at Inq.

Now [redacted] → nurse Code A → offered to go see her for dad to see her.

Her s'ments v helpful to Code A
↳ no doubt about use of syringe drivers. Its difficult, will do by increase
↳ or at some pt.

Code A → still need signed s'ment. Sat at back of Inq, shouted out.

Code A (spoke to media)
Code A → key player.

Witnesses.

send **Code A** the wit sched.

list (running order).

by after 7/4/09.

No hint of abuse so far?
Rule 11(2) addthons → all gone thru.

Syr rule → to check if any addns come thru. This could thru on nexus. — Enoym — makes clear that can't wrap docs pt together.

↳ old rules → this will have gone thru on nexus.

(*) f done + someone applied rule. addressed mind.

* do any addns fall within syr rule,

SPM not impairment :. Zygmut not apply.

Police file → disclosure list.

[redacted]

↳. check the boxes from GMC Taman checked. Need to ensure completed.

Def → Code A - went to take 32 boxes - def not involved in process - but disclosed.. to def when came to us.

Code A - didn't do full job other issues.

Need a Smart.

↳ handover note from Code A to FFW.

Code A → said to def - what get.

Code A

8/5/09 → **Code A** —

(VG) Final charges 1/5/09.

Add'l death? — ? unlawful killing at Inq:— when police will reopen.

IOP coming up. — need expert. repts.

Inq transcript — other drs. implicated. Charges added. or can we run with our case.

written doc — review immediately reviews — Coroners verdict.

to manage PS expectations will not have read all transcripts re **Code A** to add'l allegations. See explain.

[redacted]

Code A - how allegation drafted to reflect "contrib to death"

SE happy dealt with by "not int of pt" - death.

"prescriptions → potentially + proved death.

↳ seeks to deflect the Code A argument.

Hyocine - why not added? doesn't have the same effect as morphine / diamorphine.

5 year rule.

Events. — Feb - Oct 1998 - 2

Rept's GMC.

27 July 2000 - Code A .

Code A docs to copy - flagged.

Letter to Def.

Inc para.

Although the enclosed looks like a lengthy list, ~~you should know~~ it may assist you to recall at the beg of GMC [date] what I invest Code A attend [ ] unexpected docs. — took 32 boxes.

- You prev rec'd list of boxes & asked what counted.

Rowes list check all costs incurred to call + statements/ transcripts/notes disclosed.

- If we've prev had will have disclosed.

In generic rep't put declaration. Re understand duties to Ct etc.

Code A

Code A - stats kept chief med officer - did we get a copy?

↓ Have we disclosed it?

↳ check / relevant.

Code A → Drafts - tomorrow.

If not.

Coroner → Code A

Code A

Not wait for it - if 1st in time not charge charges! Not June/July

Dr

Not to call Code A -

Code A (boarder line [redacted] while

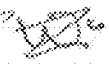
Code A

letters to all sits +.

Dating – Pharmacist – took at transcript. CI. what does he say? If anything.?

- Remind Code A – Code A
  on Code A Awaiting

-



If trustees not req as voit
to attend as an observer

letter out.

No to final stage [redacted] GMC case RC assist.

case listed June 8 tomorrow c who reg may depend on adjust made by def. expect fact 10th – 3 weeks [date]. pls call re your avail during

→ Code A or Code A

---

who have we told don't need 2 to check.

if reg to attend early morn, late after can make wrong accom.

We expect to finalise running order by late May

1 hr.

other pts - rel calling GMC - audit trail re decision - where is it?

5 - original ref.
10 - top class of police.

Code A - in
- not in

- If call can't get involved **Code A** to deal.

Code A not rep as wit.

Code A - **Code A**

- HD 2nd wife - saying could come.

Pat record - first day (14).

Panel bundle.

medical records - extract.

Code A notes.

— Not tell families - Code A

- ↳ Code A Code A Code A phone.

Code A - para support.

Code A

45 < 150 =

36°

London - attending →

attending conf.

Get better over next few wks. to be able to give better estimates.

↳ Prof Code A - relatives will give evidence unlikely to affect Prof Code A evidence.

Want these when def A. expt give evidence.

on notice of non-sitting days.

"an unlawful killing verdict" will cause use difficulty.
↳ after inquest reflect.

Prof Code A.

Hearing dates.

↳

Keep free 2 wk period. maybe sit in or transcripts, give evidence.

Dr Code A + experts – we need to be able to get hold to Q

Diary ⇒ won't be protected.

2 wks of July 2009.

1/July 2009.

Not needed first 2 wks ⇒.

1/7/09 ⇒ will need Prof Code A

last week July – 27/ 2009. out of country

Not available.

RC.

GMP - 1995 } Need to check
1998 } difference.

cap - Teamwork - delegation.
if in 1995 version?

CPR expert - guie to Prof Code A
↳ Byram Street handout.

* - also demonstrate in rept
that lead + understand.

declaration.

Videolink re addition rept.

* Wednesday → 5pm. 5.30pm - 7.30pm.

Non-sitting days.

Drug - dilutions include Hyoscine.

Pg Wos.
formalise hep
re training

Para - re admission assessment + need to write down.

interest in dispatching.

Death certificates

Go thru rept anomaly pts except front fg.

all pts

Dates (EP) drugs. = date.

Code A

Send Code A.

Controlled drugs book - Not req. for Tras / but may be addendum rept.

Use wit school.

Instructions to open

Drug - dilutions include Hyoscine.

Pg Nbs.

formalise ref. re training

Para - re admission assessment + need to write down.

Interest in Geography.

- Death certificates all pts

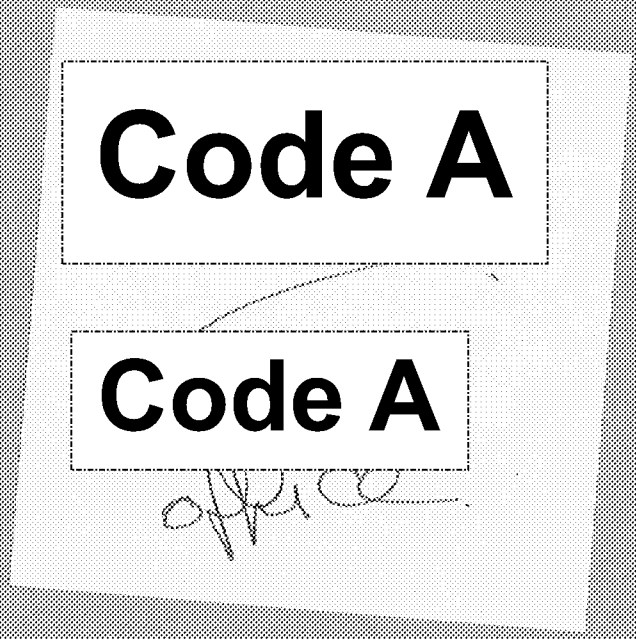
Go thru rept anonomyse pts accept front pg.

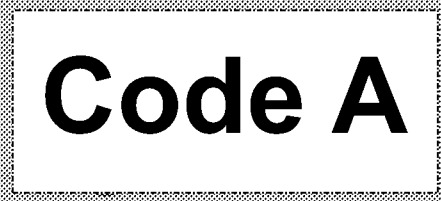
Dates (EP) drugs = date.

- send Code A. the whole school.

Controlled drugs book = Not req. for Trust but may be addendum rept.

Code A


Code A
Code A


Code A

Code A

Code A

Conference - Code A
via videolink Prof Code A .

- medical records - original pt records.
Hp access to req/copier.

- 6.04 pm. - video link.

Code A almost completed - end of weekend. - also Code A - T/C with GF re same.

Code A expl need to get 2 repts by end of Friday.

Generic rep't - by end of weekend.

Pt A. - rep't - pg 5. -
allegation 2 (iii) - diamorph / mid.
Hp pg 201. (p1849.) - prescription
looks 11/1/99. - drug chart.

Nozurain - (pg 7) - ↓ in charges 2 ECT

drug chart. - pg No. 1899.

pg 7 - 11/1/99 - needs to be dealt with between. para 0 → 11.

para 12. - failure to perform an adequate clinical assessment. ? is this so or is it "failure to note it?"

Could record to say "it is unclear whether Dr Code A acted clinical assessment but if did failed to note".

Charge 2a VII increased Norman. p 189 of pt notes. - seems to be signed by Dr Code A - (2) to check originals.

In this pt - thought poss indicated but not noted h/e in other pts indicated drugs not req'd.

Does Prof Code A agree Hof Ch.

2b. - 2a (ii) + 2a (iii) - too wide ?
Prof Code A - major criticism was too high. (para 14) dose range for diam not that wide but acceptable.
? earlier dose 40 - 60 mgs.

4b Prof Code A to do a calculation of diamorphine to show too high.

entec - 8 fold increase of morphine when diamorp. - too excessive. -

Code A - Too wide ?
an 8 fold grossly excessive, not showing wide range of other pt (40 - 200mg) but too excessive. - focus on that.

Code A - need to look at what prescribing at time not what administered.

Prof Code A to comment on 2 & ii.

Prescription of Nazran on 17/1/99 → (already on midazolam) at time. haripeladol. - switched -

Charges VI + VII — critical.
criticals
not so appears to have noted agitation.

reason not approp 18/1/99 → nursing notes "comfortable" → not req to increase nozaran.

Patient B

3 a iii –
our criticism – from Code A kept.
only diamorphine.
Query the midazolam. ? shud be included.

para 11. → reckless, not justified etc.
re midazolam / diamorphine.

→ Prof Code A agrees para 11.

lowest commencing dose.

Hypocarie – dehydration – marginal issue ∴ not relevant to bring into charges.
LD Dr Code A view.

Can Dr Code A say weekend coming ∴ prescribed wider range but 26/2/96 Monday.

The lower level to high in any event.

A wide dose range acceptable but protocol needs to be given + followed.

Most pt start 20mgs of diamorphine

2 probs - pat being switched to S/cut when cud swallow.

Also, given too higher starting dose.

Picture developing that as soon as decide dying then syringe driver £6 given.

Cud it be that Dr Code A didn't understand ½ or ⅓ left to oral / subcut morphine.

pain 10 → increased MST → becos in pain - why say not approp?

MST → sustained released prep of morphine - 2x daily → don't start on MST → start regular morphine (last 4 hrs) → give prn if necessary. After established ↓ relieve pain

amount req than use MST.

no record that pain not controlled when MST started. - Notes not clear
↳ Not add to Hof charge - too many "if's" + maybes.

Notes on 4/3 - record pt on "pain".

- para 13 - prescribing subcut infusion diamorphine 5 - 10 times higher. —

Patient 9 - Code A.

MoFAh 8 a) iii) →.

pt notes p831 - 40 - 200 mgs diamorphine 25/9.

↳ in rept to police pg 14. para 3.3.

↳ dies on 26/9/98.

para 12. - increase midazolam dose. on 23/9/98 →.
No reason for this not und in MoC. - Code A doesn't criticise. but add.

Increase prescription on 25/9/98 → not dealt with in new rept.

Problem with docs, dont know how staff know what pain was or reason for increase - midazolam 3 fold not acceptable/approp.

para 14 → 3 fold increase diamorph 23 - 25/9/98.

Increases done by nurses - Code A says gave Dr Code A a call.

3 fold increase mid – how justified?
Not following usual protocol. Need to
(ref to restlessness.) ∴ do assessment.
not sufficient just to
increase becos restless.

When relatives are complaining about
dosage increase, consultant should
want to know what's going on.

BNF – mid – warning.
use of sanctioned midaz + opiates ① intensive
care unit
not so hope
critically ill pt – need to sedate.

② pt in
terminal phases – about to
die in few days ∴ midaz to
control symptoms – must show
clear need and proper assessment
GWMH – not this type of
pt not expected to die in
a few days! old but not terminal

no definition of palliative care.

→ most pt were not dying (Code A was going to die) but still need to do a proper assessment.

Can't apply to all pt.

Use of midaz + diamorphine →
1. intensive care unit
2. imminent terminally ill.

→ our pts not in category also no monitored.

✗ Not licensed for sub cut use.
↳.

Application of drug use in hospices than use acute principals to.
Hosp setting – when pt were in for rehab.

Patient M.

Missed in 2001 kept – alcoholic liver disease – not on clerking docs. from first hospital admission

↳ Dr Code A def – if Prof Code A missed then she out. Does mention alcohol dependency.

- What notes would come with pat?
- All notes. ? Ask Code A this.

If not all notes even more impt to ensure full assessment.

Can't criticise Dr Code A not eliciting that alcoholic liver disease.

- pg 2. – "neg prescriptions crossed out + replaced with prn".

→ explain? Pat notes. pg 258 – 263 →.
see kept notes. – see top page at left hand side.

↳ type written heading.

para 10. – critical of amount of morp ∴ liver disease ?
– how strong criticism ?
↳ No resp from pt ∴ minor issue.
More critical of change from mild analgesics to opium.

q c ↳ defence ↳ not aware of liver disease.

check: what Dr Code A say to police re liver failure/disease.

↳ Inquest response

→ relatives visit / events.

Had it not been for liver disease. was oromorph too high ?

depends how monitor pt ? – not unfit to practice issue in 1995

prescription at 9 q ii) is fine if nurses knew what doing ?
Why do nurses give starting dose 5 mgs

Nurses ~~assessment~~ assessment

— in police rept ref to sept ~~not~~ needs to be oct.

① if know wer disease?
↳ presenting dr. — see pg 180. "CLF"

② if doesn't know wer dis?

Not good practice not gone thru analgesic ladder first. If Dr Code A says in prev board codeine not worked. But shud try again

↳ if morphine must make clear to nurses that start lowest level.

Also try other drugs mobilize asses correctly.

Starting dose of morphine — 10mgs — every 4 hrs ↳.

"CLF." ↳ Code A note ↳.

p180. — police st

para 11 — shud be. 15/10/98.

In charges. dont deal with 15/10/98.
— No make on a regular basis
than getting on pm basis previous
day in dont change charges.
— agree.

→ after 5x½ hrs get to steady state.
Comes not an outrageous increase
not the problem.

Is what alternative shud Dr [Code A]
have adopted?
1st - discuss w orthopedic team -
is it mobilized, operate,
codeine + NSAID, analgesic.

Can't say under no circumst
shud he not have rec'd morph.
Is Dr [Code A] can give if so much
pain — ever thot may cause
liver failure.

Much more critical of midazolam.

Generic Rept:

Issue def of palliative care/ continuing care. —

use of mid / diam in combination

⊗ ↳ opiates / mid. / care of elderly palliative.

Resp of nurses prn prescription ↑. Shld be clear understanding use of opiates also starting to higher dose.

↳ go on to say that. examples to show not understood!

No protocol for use of opiates / admin

other issue — No time to write in notes — raised with consultants — Prof F — 16hrs week does adequate time to assess + write in notes.

- Add something in kept re lack of time to do notes.
  GMP – can't give approp care to pt need to draw to attent + do something about it.

  may have some mitigation – but if not writing down assessment at beginning no baseline to treat.

  CHI → Nursing prof – highly critical of nursing notes!

Code A - sit down with Def re changes
Code A - agree dates -
admissions to be made.

Unlikely to accept NPSI

16/5/08 D — Prof Code A D.

Code A.

Hastening death . — . to check

Conference.

Where pt given between 20 - 200 Diam
20 - 80 mid.

Is safe in alleging always to high? -

No - there are 2 or 3 cases where can't say that.

↳ has to be on a pt by pt dose.

gf - some pts ok at 40mgs per day.

↳ starting dose 5 or 10 mgs.

Prob reasonable opinion 20 mgs - opiate nieve. - pt 20mg - dose equates to:
40 mgs - of oral morphine.

give - 30 mgs not to high would need look at each case when critical.

If dr Code A gives a pres verbally over phone → then goes in next day and writes presc'p + dates that day.

All other verbal prescript – nurses wrote "verbal order".

v. irregular – if nurses colluding with Dr Code A about prescribing practices.

p 190. prescription.

p 200 – undated prescription of 40mgs – under "regular presc'p" it may be that daily

p 201 – diam 80–120 mgs.

p 203 – halop 16 presc admin 16+17.

diam 120mg – dated 18 given on 17.

3 infusion

are these 2 presc for dia on 18/1

18/1 120 mg s/c diamorph. — pg. 203. pg. 190.

very confusion — maybe incorrectly dated.

- WBF for each pt charts when prescribed + given.

pg 6 Nozinan. 20/1/0

Code A →.

- 18/8/1 → are we saying that prescribing of 3 incorrect but doses ok. — being generous.

↳ diamorphine. — prescription prescription of midazolam entered. Recos usury.

admin of diamorphine ↓. ok
also haloperidol ok.

plesc to high.

~~14/2 2pm~~ 5pm.

Code A taking call from Code A

[redacted]

particularly so given that still accepting histalos in dept of Code A

[redacted]

Code A said difficulty running down. Ke charges - Code A not clear what shud go, what shud remain / be amended.

↳ to pick up further during con at 5-5.15pm - Code A on bus to london maybe running late. Code A noted.

Code A / Code A 2.30pm charges
Where above - 40 or above ↑
general terms - too high.

20mgs upward - just able ↑.
although too wide dose.
Code A suggested that reasonable body of evidence will support 20mg starting dose - Code A agrees.

failing to assess prior to prescribing opioids – Code A agrees.

~~fat a / B~~.

charges →
lower
dose too high - have not
charged below 20mgs.

→ Code A ok with this, sufficient monitoring ok. - then suff body mass evidence to support.

Code A

11/8/98 prescription - only becos what happens when back to (11) ok.

But para 18 - mdc outrageous
→ but 11/8/98 prescription?

Code A

Code A yes - good example of whole presc'n + admin problem - good to support our charges.

Patient A = redo.

40 mgs. → each one go thru.

Patient A. – Sunday at latest.

only substantial things lowest commense dose. to

might def. may complain – "potentially" out – superfluous.

Patient F.

Not charging lower dose was too high –

Code A didn't comment on the calculation.

She had 25mgs oral morph – previous. 24 hrs

12.5 mg dia – could be generous + go to 20mgs – approp.

upping of lower dose from 20 - 40 mgs what's the pt 2.

Code A appears that Dr Code A — forcing the ~~upper~~ lower level to go up, can't go lower.

changed dose range to 4 40mg why? becos in minimum

Police inquiry - don't refer. -

* Code A kept

CHI kept —.

Stage 2 - further 27/4/09.

11am.

Code A

- Coroners Inq - completed.

- still go ahead in June. -

Code A - as far as inq concerned - no changes.

Slight fly is the 11th inquest - Code A SE → have agreed get on with GMC hearing.

- GMC position - not hold June/July - suspect will be afterwards

↳ if inquest → try to vit summons then would apply to set aside.

Inquest — not effect June & - 21 August.

2 none 18/6/ + 23/7./

any other note cutting day.

process of putting together will take first 3 or 4 weeks.

keep (H) period.

Going to ask to call most people got to call.

Running order

↳ Code A - not trying to flag up can't rec'd.

Prof Code A - expert rep't how changes thing 2. unsure.

Draft HofC - later this week Unnecessity.

→ anyother outstanding →

Legal arguments - unlikely to be any? → come back promptly

→ videolink → voting to all visits tomorrow. —

bt adjudication know video-link

Dr Code A - delineate availability.

may be any availability → NZ →
right. panel to be flexible.

mid to late July - don't believe
panel.

slight problem. → see things puzzled

when police pleas print - index.

start time list of additional
material - made available.

→ no indication - 22 boxes of unused
materials -

↳ not immediately - unless something
we are.

↳ referred Code A to go back to police.

reliant on **Code A** →

↳ feeling not a bad as it looks
– not saying can't proceed in June

↳ GMC nothing to add.
Def – " "

↳ keg contact with Def + GMC.
If keg will give you a shout if problem.

– one other thing – **Code A** not heard back from solicitor.

[redacted] – wanted to take part in Ing & – had raised video evidence.

↳ supposed – play a video or tape

↳ maybe need to have recording to hand. ↳

Code A – Def close down.

Q
short - supplement

- ask to comment about prescription on 25/9 and the increase. — was it acceptable/outrageous.

on 25/ Sept - ups the minimum dose from 20-40 mgs.
- comments.

- midaz upped - shud the have reassessed

Dr Code A not necessarily for mass if nursing obs.

supplemental.

IOP – chronology.

Expert points.

to check pt record - entries.

put in generic rept - palliative care & also combination of midaz + diamorph

what is purpose of prescribe drugs?

midaz - terminal agitation and restless.

opiates → (cause restlessness)
↳ also hypoxic - cud treat O2.

To check medical notes pt H, prov by police, to check had old notes +

Code A

Code A

Room at GMC.

LP.

original pt records.

LP Ray.

Need to see original medical notes. - re Putlock.

Code A

check.

What pt records came with pt transfer.

"calf" - check policy smart for Code A

Code A

Code A

General Medical Council - Dr

Code A

	Action	Date to complete	Responsibility	Comments
1.	~~Expert reports~~	~~All drafts by 14.04.04~~ ~~Finalised versions by 17.04.09~~	~~Dr~~ Code A	
2.	~~Expert Report – BNF references~~	~~ASAP~~	Code A	~~Provide to Dr~~ Code A ~~page numbers from relevant BNF~~
3.	~~Expert Report – GMP 1995 & 1998~~			Review to ascertain position in ~~1995/~~1998 GMP re delegation of responsibilities to team – ~~both set out almost identical requirement~~s
4.	~~Forward to GF CPR extract – expert witnesses and wording for declaration~~			
5.	~~Death Certificates – send~~ to Professo Code A	ASAP		7 sent except for Code A and Code A
6.	~~Wessex Protocol – clarify whether an updated version available~~	~~ASAP~~		
7.	~~Consider Rule 5 position~~	~~ASAP~~	~~RC~~	~~Initial referral to GMC in August 2002 under PCC (Procedure) Rules 1998 (events referred occurred between Feb-October 1998) (patients~~ Code A ~~and~~

				Code A). ~~Other cases referred under Rule 11(2) – sufficiently similar (?)~~

8.	~~Police File~~		Code A	Code A ~~to find~~ Code A ~~handover note.~~
9.	Counsel's advice re 5 year Rule	ASAP		
10.	~~GMC papers (2 boxes)~~			~~Reviewed by~~ Code A ~~check completed~~
11.	~~Witness running order~~	w/c 20.0407	Code A	
12.	~~Remind~~ Code A to consider issue re Code A			
13.	~~Obtain Inquest transcripts and~~ summary/coroners determination – Forward to ~~Counsel~~			~~Look at evidence if any from Watling~~ (Pharmacist) ~~does this change position re calling him?~~
14.	~~Review Inquest transcripts and~~ summary/~~coroners verdict~~		W	Consider impact on ~~HOC~~. (Also ~~keep in mind any matters which concern action of other doctors)~~
15.	~~Finalise HOC~~	~~01.05.09~~		~~Last date for sending out NOH 08.05.09~~
16.	~~Professor~~ Code A			**Discuss with** Code A

	~~unavailability during hearing period.~~			

17.	Provide dates of non-sitting days to Professor Code A		Code A	18.06.09 - 23.07.09
18.	Discuss with Code A need to clear diary for 3rd week of hearing			
19.	Send original Drugs book to Professor Code A		Code A	
20.	Witness schedule send to Code A	17.04.09	Code A	Word and excel format
21.	Panel Bundles			
22.	Obtain original medical records – all patients – from police		Code A	To be delivered to GMC on 08.06.09.
23.	Ensure we have all witness statements and transcripts for all witnesses on which we intend to rely			
24.	Code A – statistics report for Chief Med office – have we disclosed it	End of may	Code A	

	Action	Date to complete	Responsibility	Comments
	~~Letters to all families following inquest~~ asap			
	Line up witnesses			
	Line up expert			
	Accommodation – witnesses – Holiday Inn			
	Accommodation – Expert –			
Code A	Accommodation – Code A and Code A			
	Witness summons – Prepare and issue			
	~~Letters to all families following inquest~~			
	Line up witnesses			
	Line up expert			
	Code A (GP says not fit			

	to attend) **Code A**			

Case Plan and costing: Dr Code A

Presumptions:

- Police have provided all their material in well ordered format to GMC – yes although some documents may be missing, meaning more liaison will perhaps be needed
- Experts instructed by the police will be willing to act in GMC proceedings and, whilst they may need to provide consolidated reports which address GMC issues, new experts will not be required
- All witnesses will already have made a police statement and will only require production statement and witness care – some of the witnesses are strongly requesting further interviews and to make additional statements. (At present we are still assessing this and new statements do not form part of this costing.)
- There are 10 cases which have been referred (there were 5 in the Rule 6 letter of 11 July 2002 – we do not have details of the additional 5 cases but presume that they are similar) – there are potentially 13 cases
- The case will proceed under GMC PPC and PCC (Procedure) Rules 1988 as it was first notified to GMC in 2002. The additional cases will be added under proviso to Rule 11(2) as sufficiently similar
- We will use a senior junior (not a QC) (probably from London) but they will want to negotiate slightly higher rates for class 5 case.
- The hearing will last 40 days in London (witnesses are on the south coast)

Code A – To Do List / TET handover

4 November 2008

1. **Police disclosure issue**

   (a) TET to go to Counsel for advice

   (b) We have list, what Police have said, should we send it back?, does we should request / ought to get, is police approach adequate. Don't send list to counsel – just advice.

   (c) Code A instructed

2. **Fees**

   (a) Received fee notes - £30,094.70 (TK) and £17,419.38 (BF) (Estimate – counsel's fees - £116,500)

   (b) Our fees – currently - £158,936.60 (Estimate - £177, 886)

   (c) Expert's fees – currently £14,600 – Code A has no outstanding fee notes (Estimate £30,000)

   (d) Re-do estimate…….

3. **Expert**

   (a) Awaiting confirmation from Code A – he is speaking to Code A

   (b) Look up contact details for other experts – Code A Prof Code A Code A

4. **GMC docs**

   (a) Code A gone – few docs to copy most of it we've already had – labelled which to copy

5. **Coroner**

   (a) Code A written to confirm dates of Inquest

(i) Additional documentation received – we have had all of this previously

(b) Coroner has listed witnesses – some differences, he is calling Code A and Code A

(i) Witness list – copy and send to counsel for comment

6. **Defence**

(a) have raised that they have further disclosure requests – have asked them to confirm what they are

7. **Consultant Statements**

(a) Code A – check that we have served s'ments of L/T/R on defence - get scanned in

(b) Reid – Code A has chased exhibit for blank medical record

(c) Code A counsel for decision as which to call – Code A No, Code A Yes, Code A

8. **Outstanding witness statements**

(a) Issues re scanning in statements – can Code A sort out backlog?

(i) scanned/disclosed witness list Code A to update

(A) Concern that some signed statements have been filed in wrong place

(b) Evidence of Code A - VERY URGENT – Not doing anything with

(i) Chased 24/10/08

(ii) Code A to chase again (no phone number – can we find out where he works)

(c) Witness statement of Code A (relative of Code A

(i) Draft sent to him, chase – Keep chasing

(d) Witness statement of Code A (relative of Code A)

(i) Received signed statement – Code A to scan and disclose

(e) Finalised and disclosed but need scanning and update on list dates of disclosure:

(i)
(ii)
(iii)
(iv)
(v)
(vi)
(vii)
(viii)

Code A

(f) Code A finalised statement

(i) she is checking one of the exhibits (re her notes on the back of the Haslar notes)

(ii) Coroner has confirmed to her that he is asking for permission from S of State to add her mother to the Inquest

(g) Witness statement of Code A (to the extent that a production statement is required for police documents) Defence have confirmed that they do not need Not req. – Def ✓

(h) Witness statement of Code A - [redacted] - may not be able to give evidence - Code A to continue chasing for signed s'ment (no phone number - get from PCT?)

(i) Witness statement of Code A (this is just a production statement) Code A has chased Code A to chase again?? liaise with mother - keep chasing

(j) Code A - supplementary statement to produce cards – received?

(k) Witness statement of Code A (this is just a production statement) - received

back with a number of amendements. Code A to amend and re-send.

(l) Witness statement of Code A - 4/7/08 she rang to say s'ment sent to RCN – we have chased again

(m) Witness statement of Code A – she has added additional information – Code A to scan to Code A for his advice

(n) Code A we cannot trace this witness - have we done sufficient to show best endeavours?) - Code A has compiled a little pack of what we've done - Code A contact Navy – also NMC – gel

(o) Code A - we think he wants to amend his s'ment??? Code A yet to take statement, every time she calls he says he has not got time to give statement

(p) Code A - has amended statement - Code A to chase again

* Code A – take off.

Code A

General Medical Council – Dr Code A

Witness schedule

No.	Day	Surname	First Name	Job/Title	GMC Statement	Full or Read	Comments
PATIENT WITNESSES							
		PT A - Code A					
1	Day 2 9.6.09 a.m.	Code A		Daughter	Y		Sensitive personal data needs to give written confirmation from doctor — Call.
2	9.6.09 a.m.	Code A		Doctor	N		Explains prescription of 100 mgs of Nozinan – *confirming statement needed* — Find Call
		PT B - Code A					
3	9.6.09 p.m.	Code A		Son	Y		Has a number of practical issues about attending the hearing. — Call.
		PT C - Code A					
		NONE OTHER THAN EXPERT		-			
		PT D - Code A					
4	Day 3 10.6.09 a.m.	Code A		Daughter	Y		Need T/ number — T.

		PT E - Code A				
5	10.6.09 a.m.	Code A	Daughter	Y		
6	10.6.09 a.m.		Daughter	Y	Code A sister [redacted]	
7	10.6.09 p.m.		Nurse	Y	See Interviews in F Code A File READ BEFORE DECIDING WHETHER OR NOT TO CALL	
		Pt F – Code A Code A				
8	Day 4 11.6.09 a.m.	Code A	Daughter	Y		
9	11.6.09 a.m.	Code A	Daughter	Y		
10	11.6.09 a.m.		Nurse	N	Unable to trace. Possibly nee Phoenix – can't find	
11	11.6.09 p.m.		Doctor	Y	Was being deployed to Iraq	
		PT G – Code A Code A				
12	Day 5 12.6.09 a.m.	Code A	Step-son	Y	Has a lot to say. Very involved in inquest.	
13	12.6.09 a.m.	Code A	Friend	Y	Has bad back - unable to travel	
14	12.6.09 p.m.		Nurse	N	Would like to read if witness unavailable	
		Pt H – Code A Code A				
15	Day 6 15.6.09 a.m.	Code A	Son	N	Has a lot to say but difficult to get hold of. Very involved in inquest.	
16	15.6.09 a.m.	Code A	Son	N	Read by agreement -	
~~17~~	~~5.6.09 a.m.~~		~~Son~~	~~Y~~	~~I CAN NOT FIND THIS STATEMENT~~	
18	15.6.09 p.m.		Wife	Y	*I would prefer not to call this witness – is she keen to give evidence? She is described by one of the sons as*	

Morning.

2pm onward

Need to Mouth

Code A

Not to be too forceful

Find out

							[redacted] *and she ends her statement asking for compensation!*
19	Day 7 16.6.09 a.m.	Code A		Doctor	Y		~~Read~~ Read – if agreed.
20	16.6.09 a.m.	Code A		Doctor	Y		Code A to clarify.
		Pt I – Code A Code A					
21	16.6.09 p.m.	Code A		Nephew	N		*Unwilling witness. We would like to call this witness. Saw Aunt regularly. Get letter he refers to from* Code A Code A *Sols?*
22	16.6.09 p.m.	Code A		Ortho Consultant	N		*This witness writes a useful report on this patients post operative complications. If possible I would like to call or read him. Not essential.*
		Pt J – Code A Code A					
23	Day 8 17.6.09 a.m.	Code A		Wife	Y		
24	17.6.09 a.m.	Code A		Daughter	Y		
25	17.6.09 p.m.			SHO	N		*Made note at Portsmouth – not for resusc. But makes clear not expecting to die. We would like to read this witness.*
							There are many witnesses who speak of Pt J being conscious and chatty a few days before death. Is this to be challenged? If so we may wish to call further witnesses.
		Pt K – Code A Code A					
26	Day 9		Code A	Code A	Y		Very extensive statement. The evidence will have to be

→ Pg 5.

	18.6.09 a.m.						limited.
27	18.6.09 a.m.	Code A		Code A	Y		Code A
28	18.6.09 p.m.			Doctor	Y		
29	Day 10 19.6.09 a.m.			Doctor	Y		Prognosis re: patient's kidney function was not good
		Pt L - Code A Code A					
30	19.6.09 a.m.	Code A		Husband	Y		
31	19.6.09 a.m.			Daughter	Y		

NURSES

		NAME	1ST NAME	GMC ?	Relevant to -	FULL OR READ	COMMENTS
		Code A		N	Code A		
				Y			
				Y			
				N			No response after initial contact.
				Y	Code A		Extremely nervous witness - probably best not to call as oral evidence will be weak.
				Y	Code A		
				Y			Sensitive personal data [redacted]
		Code A		Y			
				Y			
				N			cant find
				N	Code A		
				Y			Contact via Code A - Legal Services - 02380 627451
				N			
				Y			
				N			~~Tried to get expert report but he is~~ now unwilling.
				Y			
				Y	Code A		
		Code A					emailed 11/6/09

DOCTORS					
A B	Code A	Y Y	Code A	Code A - other mobile?	Code A
CONSULTANTS					
C	Code A	Y	Code A		
D		Y			
E		Y		Lives in New Zealand Not calling (?)	
~~**PHARMACIST**~~					
	Code A				
POLICE					
	Code A			one or other.	
EXPERT					
	Code A				

WITNESSES WHO HAVE MADE GMC STATEMENTS NOT BEING CALLED BY GMC								
		Code A		Nurse	Y	Code A		Very partial witness, inaccurate on occasions. Do Not Call
				Nurse	Y			Partial and adds nothing
				Physio	Y			No recollection, confirms notes
				Doctor	Y			Unwilling witness.
				Nurse	Y			
				Doctor	Y			Does not add
				Doctor	Y			Does not add to notes, last saw patient 2 months before death

4) wait until Code A has confirmed remainder.

	A	B	C	D	E	I	O
1	Surname	Name	Job/Title	Patient	Statement	Relevant to:	Comments
2	Code A		Daughter	Code A	Y	Code A	
3			Nurse		Y		
4			Doctor		Y		
5			Doctor		Y		Unwilling witness.
6			Nurse		Y		
7			Nurse		Y		
8			Nurse		N		Unable to trace. Possibly nee Phoenix
9			Nurse		Y		
10			Doctor		Y		Was being deployed to Iraq
11			Nurse		Y		
12			Doctor		Y		
13			Nurse		Y		
14			Nurse		N		
15			Step-son	Code A	Y	Cunningham	Has a lot to say. Very involved in inquest.
16			Nurse		Y		
17			Nurse		Y		Sensitive No LETTER
18			Daughter	Code A	Y		
19			Doctor		N		Unable to trace.
20			Nephew	Code A	N		Unwilling witness.
21			Nurse		Y		
22			Wife	Code A	Y		
23			Son		Y		Has a number of practical issues about attending the hearing.
24			Doctor		Y		Lives in New Zealand
25			Doctor		Y		
26			Daughter	Code A	Y		Code A recently spoke to her
27			Daughter		Y		
28			Daughter		Y		Code A sister - Sensitive
29			Wife		Y		
30			Daughter		Y		
31			Son		N		

Code A

Code A

Code A

Code A

	A	B	C	D	E	I	O
32	Code A		Doctor		Y	Code A	
33			Doctor		Y		Code A other mobile?
34			Doctor		Y		
35			Code A	Code A	Y		
36					Y		Code A
37			Doctor		Y		left to FC conversation - dates
38			Daughter	Code A	Y		
39			Misc		Y		Contact via Code A Legal Services - 02380 627451
40			Friend	Code A	Y	Code A	Has bad back - unable to travel
41			Nurse		Y		
42			Husband	Code A	Y		
43			Doctor		Y		
44			Doctor		Y		
45			Doctor		Y		
46			Physio	(N/P)	Y		
47			Nurse		N		
48			Nurse		N	Code A	No response after initial contact.
49			Nurse		Y		
50			Pharmacist		N		Tried to get expert report but he is now unwilling
51			Nurse		Y		Extremely nervous witness - probably best not to call as oral evidence will be weak.
52			Friend		Y	Code A	Sensitive [redacted] - needs to give written confirmation from doctor
53			Son	Code A	N		Has a lot to say but difficult to get hold of. Very involved in inquest.
54			Son		Y		Code A
55			Son		N		
56			RCN		Y		

Dr. Code A P/S. 16/2/05. Production Sment.

wit/cnt
Bodnar

General Medical Council – Dr Code A

Witness schedule

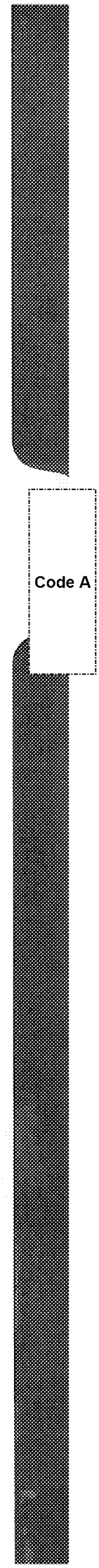
	Surname	Name	Job/Title	Comments
1.			Daughter	
2.			Nurse	
3.			Doctor	
4.			Doctor	
5.			Nurse	
6.			Nurse	
7.			Nurse	
8.			Nurse	
9.			Doctor	
10.			Nurse	
11.			Doctor	
12.			Nurse	
13.			Nurse	
14.			Step-son	

Code A

15.			Nurse	
16.			Nurse	
17.			Daughter	
18.			Doctor	
19.			Nephew	
20.			Nurse	
21.	**Code A**		Wife	
22.			Son	
23.			Doctor	
24.			Daughter	
25.			Daughter	
26.			Daughter	
27.			Wife	
28.			Daughter	

29.		Son	
30.		Doctor	
31.		Doctor	
32.		Doctor	
33.		Code A	
34.			
35.	Code A	Doctor	
36.		Daughter	
37.		Misc	
38.		Friend	
39.		Nurse	
40.		Husband	
41.		Doctor	
42.		Doctor	

43.	**Code A**		Doctor	
44.			Physio	
45.			Nurse	
46.			Nurse	
47.			Nurse	
48.			Pharmacist	
49.			Nurse	
50.			Friend	
51.			Son	
52.			Son	
53.			~~Son~~	
54.			RCN	


Code A

GENERAL MEDICAL COUNCIL

DR Code A HEARING PERIOD (JUNE 2009)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
8 June	9 June	10 June	11 June	12 June	13 June	14 June
15 June	16 June	17 June	18 June	19 June	20 June	21 June
22 June	23 June	24 June	25 June	26 June	27 June	28 June
29 June	30 June					

expert not available

consultants london

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GENERAL MEDICAL COUNCIL

DR Code A HEARING PERIOD (JULY 2009)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
		1 July expert n/a	2 July	3 July	4 July	5 July
6 July	7 July	8 July Already Knew. expert n/a	9 July	10 July	11 July	12 July
13 July	14 July	15 July	16 July	17 July	18 July	19 July
20 July	21 July	22 July	23 July X	24 July	25 July	26 July
27 July	28 July	29 July	30 July	31 July		

GENERAL MEDICAL COUNCIL

DR Code A HEARING PERIOD (AUGUST 2009)

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
					1 August	2 August
3 August	4 August	5 August	6 August	7 August	8 August	9 August
10 August	11 August	12 August	13 August	14 August	15 August	16 August
17 August	18 August	19 August	20 August	21 August	22 August	23 August
24 August	25 August	26 August	27 August	28 August	29 August	30 August
31 August						

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C1

CHRONOLOGY

DR Code A

February 1998 – October 1998	Original alleged period of inappropriate prescription to 5 patients (aet 75-91) at Gosport War Memorial Hospital, all of whom died at the hospital where Dr Code A was a part-time clinical assistant (Code A and Code A) (pages 4-8)
28th April 2000	Dr Code A resigned from part-time employment and continued in general practice (pages 413 and 424)
27th July 2000	Hampshire Constabulary first informed GMC of concern re Dr Code A re Code A (page 9)
21st June 2001	First IOC Hearing (only re Code A **No order** (No transcript available)
10th July 2001	Professor Code A report re Code A Death occurred earlier as a result of drugs than it would have done from natural causes (pages 19 – 52)
14th August 2001	Hampshire Constabulary letter: Insufficient evidence to support a viable prosecution against Dr Code A re Code A but continuing enquiries re other deaths and further review re Code A (page 13)
18th October 2001	Report of Dr Code A re Code A Code A and Code A pages 53-58)
12th December 2001	Report of Professor Code A re 5 patients (pages 59-97)
6th February 2002	CPS decided not to institute criminal proceedings re Code A and disclose their papers to GMC (pages 15 and 16)
21st March 2002	**Second IOC Hearing** (partial transcript pages 413-431) **No order** (full transcript available)

End March 2002	Dr Code A undertaking to the Health Authority not to prescribe opiates or benzodiazepines ceased (pages 453-4)
11th July 2002	Rule 6(3) Notice (pages 4-8)
27th August 2002	Response from MDU for Dr Code A (pages 404 - 412) (plus partial transcript of second IOC Hearing)
29th August 2002	PPC referred Dr Code A to PCC (hearing still awaited) (pages 1-399)
13th September 2002	Letter from GMC qua "President" to Dr Code A giving notice of third IOC Hearing
19th September 2002	**Third IOC Hearing** (pages 1-455) (transcript pages 437-455) **No order and a judgment that there was no new material since the second Hearing and it would be unfair to consider the matter further**
September 2002 ... to date and continuing	Police investigation continues (pages 458 and 460). First papers of selected cases likely to go to CPS in December 04 or early 2005
February 2003	5 experts commence analysis of 88 Gosport War Memorial Hospital patients' records (page 460) work expected to finish October 2004. Classification of cases into 3 categories.
May 2004	Other experts (geriatric and palliative care) instructed to judge category 3 cases (page 460)
24th September 2004	GMC Letter of notification of 7th October IOC Hearing to Dr Code A
27th September 2004	Dr Code A letter confirming intention to attend IOC Hearing on 7th October
27th September 2004	Letter from MDU for Dr Code A seeking adjournment and questioning compliance with rule 5

30th September 2004	Receipt by GMC of electronic copy of witness statement from Detective Chief Superintendent Steven Watts and supplementary documents re 19 further patients (pages 456 – 507). These pages (omitting irrelevant patients) were forwarded electronically forthwith to MDU and delivered in hard copy to MDU on the same day.
30th September 2004	GMC letter to MDU imparting refusal of adjournment by Chairman of the Committee and questioning the challenge to 24th September rule 5 compliance
30th September 2004	MDU letter to GMC re letter of 30th September from GMC maintaining rule 5 non-compliance, concern re absence of documentation and concerning merits e.g. re absence of present cause for concern from Dr Code A practice
30th September 2004	GMC letter to Dr Code A (page 508)
1st October 2004	Hard copy of statements and documents (pages 456 – 507) delivered to Dr Code A as agreed with MDU.
7th October 2004	**Fourth IOC Hearing**

Code A

8 → SLE.
9 → RC to Friday – Partner available May Trims.

K2 15 (MT cover.)
16 SLE.
17 Code A.
18 paralegal cover. also.
19

K3 22 para
23 para
24 – Code A that. next up with Code A para.
25 –
26 –

K4 29 – Code A – Para
30 – Para
1 – Code A – Para
2 – Para
3 – [redacted] – Code A off but contacted.

K5 6 para
7
8
9 take out GMC
10

13/7 para
14 para. SE
15 SE para
16 SE para
17 para.

20 para
21 ↓
22
23 SE
24 SE

27 para.
28
29
30
31

17/8 — Annual leave (20 weeks.)
Code A around.
Code A

IN THE MATTER OF THE MEDICAL ACT 1983

AND IN THE MATTER OF

THE GENERAL MEDICAL COUNCIL

AND

DR Code A

NOTICE OF HEARING

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1. At all material times you were a medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital ("GWMH"), Hampshire.

2. a) i) Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care,

ii) Between 5 and 10 January 1996 you prescribed Oramorphine 5mg 5 times daily, as well as Diamorphine with a dose range of 40 – 80 mg over a twenty-four hour period to be administered subcutaneously ("SC") on a continuing daily basis,

iii) On 11 January you prescribed Diamorphine with a dose range of 80 – 120 mg and Midazolam with a range of 40 – 80 mg to be administered SC over a twenty-four hour period,

iv) On 15 January a syringe driver was commenced at your direction containing 80 mg Diamorphine and 60 mg Midazolam as well as Hyoscine Hydrobromide,

v) On 17 January the dose of Diamorphine was increased to 120 mg and Midazolam to 80 mg,

vi) On 18 January you prescribed 50 mg Nozinan in addition to the drugs already prescribed,

b) In relation to your prescriptions described in paragraphs 2a (ii) and 2a (iii):

i) the lowest doses prescribed of Diamorphine and Midazolam were too high;

ii) the dose range was too wide,

iii) the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs.

c) The doses of Diamorphine administered to the patient on 15 and 17 January were excessive to the patient's needs.

d) Your prescription described at paragraphs 2a) vi) in combination with the other drugs already prescribed were excessive to the patient's needs.

e) Your actions in prescribing the drugs as described in paragraphs 2a) ii), iii), iv), v), and vi) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient A.

3. a) i) Patient B was admitted to Daedalus Ward at the GWMH on 22 February 1996,

ii) On 24 February you prescribed the patient Morphine Slow Release Tablets (MST) 10 mg twice a day,

iii) On 26 February you increased the prescription for MST and prescribed Diamorphine with a dose range of 80 mg - 160 mgs and Midazolam with a dose range of 40 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

iv) On 5 March you prescribed Diamorphine with a dose range of 100 - 200 mg and Midazolam with a dose range of 40 mg – 80 mg over a twenty-four hour period to be administered SC and a syringe driver was commenced containing Diamorphine 100 mg and Midazolam 40 mg.

b) In relation to your prescriptions for drugs described in paragraphs 3a) iii) and iv):

i) the lowest commencing doses prescribed on 26 February and 5 March of Diamorphine and Midazolam were too high;

ii) the dose range for Diamorphine and Midazolam on 26 February and on 5 March was too wide,

iii) the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs.

c) Your actions in prescribing the drugs described in paragraphs 3a) ii), iii) and/or iv) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient B,

d) In relation to your management of Patient B you:

i) did not perform an appropriate examination and assessment of Patient B on admission,

ii) did not conduct an adequate assessment as Patient B's condition deteriorated,

iii) did not provide a plan of treatment,

iv) did not obtain the advice of a colleague when Patient B's condition deteriorated.

e) Your actions and omissions in relation to your management of patient B were:

i) inadequate,

ii) not in the best interests of Patient B.

4. a) i) On 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care,

ii) On 3 March 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20-80mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs described in paragraph 4a) ii):

i) the dose range of Diamorphine and Midazolam was too wide,

ii) the prescription created a situation whereby drugs could be administered to the patient which were excessive to the Patient C's needs,

c) Your actions in prescribing the drugs described in paragraph 4a) ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient.

5. a) i) On 6 August 1998 Patient D was transferred to Daedalus Ward at GWMH for continuing care observation,

ii) On or before 20 August you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20mg - 80mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs as described in paragraph 5a (ii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient D which were excessive to the patient's needs,

c) Your actions in prescribing the drugs as described in paragraph 5a (ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient D.

6. a) i) Patient E was admitted to Daedalus Ward at GWMH on 11 August 1998 after an operation to repair a fractured neck of femur at the Royal Haslar Hospital,

ii) On 11 August you prescribed 10 mg Oramorphine 'prn' (as required),

iii) On 11 August you also prescribed Diamorphine with a dose range of 20 mg - 200 mg and Midazolam with a dose range of 20 mg - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs described in paragraph 6a) (iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient E which were excessive to the patient's needs.

c) Your actions in prescribing the drugs described in paragraph 6a) ii) and/or (iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient E.

7. a) i) Patient F was admitted to Dryad Ward at GWMH on 18 August 1998 for the purposes of rehabilitation following an

operation to repair a fractured neck of femur at the Royal Haslar Hospital,

ii) On 18 August you prescribed Oramorphine 10 mg in 5 ml 'prn' (as required),

iii) Between 18 and 19 August you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs described in paragraph 7a) (iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient F which were excessive to the patient's needs.

c) Your actions in prescribing the drugs described in paragraphs 7a) ii) and/or iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient F.

8. a) i) Patient G was admitted to Dryad Ward at GWMH on 21 September 1998 with a painful sacral ulcer and other medical conditions,

ii) On 21 September 1998 you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

iii) On 25 September you wrote a further prescription for Diamorphine with a dose range of 40 - 200mg and Midazolam with a dose range of 20 – 200mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescriptions for drugs described in paragraphs 8a) (ii) and/or (iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs.

c) Your actions in prescribing the drugs described in paragraphs 8a) (ii) and/or (iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient G.

d) You did not obtain the advice of a colleague when Patient G's condition deteriorated.

9. a) i) Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease as a result of alcoholism and other medical conditions,

ii) On 14 October you prescribed Oramorphine 10 mg in 5 ml, with a dose of 2.5 ml to be given every four hours thereafter as needed, following which regular doses of Oramorphine were administered to the patient,

iii) On or before 16 October you prescribed Diamorphine with a dose range of 20 mgs - 200 mgs to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

iv) On or before 17 October you prescribed Midazolam with a range of 20 mgs - 80 mgs to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9a (ii) was:

i) inappropriate,

ii) potentially hazardous,

iii) likely to lead to serious and harmful consequences for Patient H,

iv) not in the best interests of Patient H.

c) In relation to your prescription described in paragraph 9a) iii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient H which were excessive to the patient's needs.

d) Your actions in prescribing the drugs described in paragraphs 9a) ii), iii) and/or iv) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient H.

e) You did not obtain the advice of a colleague when Patient H's condition deteriorated.

10 a) i) Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital,

ii) On 12 April you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

iii) On 12 April a syringe driver with 80 mgs Diamorphine and 20 mgs Midazolam over twenty-four hours was started under your direction but later the dose was reduced to 40 mgs by Dr Code A

b) You did not properly assess Patient I upon admission. This was:

i) inadequate,

ii) not in the best interests of Patient I.

c) In relation to your prescription for drugs described in paragraph 10a) ii):

i) the dose range was too wide,

ii) the prescription created a situation whereby drugs could be administered to Patient I which were excessive to the patient's needs.

d) Your actions in prescribing the drugs described in paragraph 10a) ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient I.

e) The dosage you authorised/directed described in paragraph 10a) iii) was excessive to Patient I's needs. This was:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient I.

11. a) i) Patient J was admitted to Dryad Ward at GWMH on 23 August 1999 following his treatment at the Queen Alexandra Hospital where the patient had been admitted as an emergency following a fall at home,

ii) On 26 August 1999 you gave verbal permission for 10 mg of Diamorphine to be administered to Patient J,

iii) You saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death',

iv) You did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition,

v) On 26 August you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

vi) On 26 August you also prescribed Oramorphine 20 mg at night.

b) In relation to your prescription for drugs described in paragraph 11a) v):

i) the lowest doses of Diamorphine and Midazolam prescribed were too high;

ii) the dose range was too wide,

iii) the prescription created a situation whereby drugs could be administered to Patient J which were excessive to the patient's needs.

c) Your actions in prescribing the drugs described in paragraphs 11a) ii) and/or v) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient J.

d) Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11a) iv) was:

i) inappropriate,

ii) not in the best interests of Patient J.

12. a) i) Patient K was admitted to Dryad Ward at GWMH for continuing care on 21 October 1999 from Queen Alexandra Hospital She was reported to be suffering from chronic renal failure and multi infarct dementia,

ii) On admission you prescribed Morphine solution 10mg in 5 ml as required,

iii) On 18 and 19 November there was a deterioration in the Patient K's condition and on 18 November you prescribed Fentanyl 25 µg by patch,

iv) On 19 November you prescribed Diamorphine with a dose range of 40 - 80 mg Midazolam with a dose range of 20 to 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) The prescription on admission described in paragraph 12a) ii) was not justified by the patient's presenting symptoms.

c) In relation to your prescription for drugs described in paragraph 12a) iv):

i) the lowest doses of Diamorphine and Midazolam prescribed were too high;

ii) the dose range was too wide,

iii) the prescription created a situation whereby drugs could be administered to Patient K which were excessive to the patient's needs,

d) Your actions in prescribing the drugs described in paragraphs 12a) ii), iii) and/or iv) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient K.

e) You did not obtain the advice of a colleague when Patient K's condition deteriorated.

13. a) i) Patient L was admitted to Daedalus Ward at GWMH on 20 May 1999 following a period of treatment at the Haslar Hospital for a stroke;

ii) On 20 May 1999 you prescribed:

a) Oramorphine 10 mgs in 5 mls 2.5-5mls;

b) Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis;

c) Midazolam with a dose range of 20 to 80 mgs to be administered SC;

iii) You further prescribed Oramorphine 10 mgs in 5 mls 4 times a day and 20 mgs nocte (at night) as a regular prescription to start on 21 May 1999;

iv) Doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient in 21 and 22 May 1999.

b) In relation to your prescription for drugs described in paragraph 13 a) ii) and/or iii):

i) There was insufficient clinical justification for such prescriptions;

ii) The dose range of Diamorphine and Midazolam was too wide;

iii) The prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs.

iv) Your actions in prescribing the drugs described in paragraph 13 a) ii) and or iii) were:

a. Inappropriate;

b. potentially hazardous;

c. Not in the best interests of patient L.

c) You did not obtain the advice of a colleague when Patient L's condition deteriorated.

14. a) You did not keep clear, accurate and contemporaneous notes in relation to Patients A, B, C, D, E, F, G, H, I, J K and/or L 's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed and/or directed by you,

b) Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were:

i) inappropriate,

ii) not in the best interests of your patients.

15. a) In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K, L

b) Your failure to assess the patients in paragraph (a) appropriately before prescribing opiates was not in their best interests.

"And that in relation to the facts alleged you have been guilty of serious professional misconduct."

IN THE MATTER OF THE MEDICAL ACT 1983

AND IN THE MATTER OF

THE GENERAL MEDICAL COUNCIL

AND

DR Code A

Patient Schedule

Patient A -
Patient B -
Patient C -
Patient D -
Patient E -
Patient F -
Patient G -
Patient H -
Patient I -
Patient J -
Patient K -
Patient L -

Code A

[redacted]

[redacted]

[redacted]

Field Fisher Waterhouse

Information Services

Dr Code A - news | 17 April 2009

Please note that this information is confidential. It is for internal use only and must not be disclosed to clients or to anyone else outside Field Fisher Waterhouse LLP.

News articles

Poor access to QA could risk health
Portsmouth Today, 17 April 2009

Patients could miss hospital appointments and put their health at risk because of problems getting to Portsmouth's new 'superhospital', it has been claimed.
The fears have been raised as a new group is formed to try to work out ways to make it easier for Gosport residents to get to the rebuilt Queen Alexandra Hospital.

Campaigners fear that the closure of Gosport's Haslar Hospital in June, which will see services shifted to the new hospital in Cosham, will see motorists battling their way round the A32 to get to appointments.

If they choose to use public transport they will have to travel to Gosport Harbour and then catch a ferry and two buses.

Some fear patients will simply choose not to go.

Tory County councillor Code A, who also represents Gosport's Alverstoke Ward on the borough council, is the chairman of a working group which will look at ways of improving access to QA for patients who are further away.

He said: 'I think the access problems could cause people not to go to follow-up appointment.

'This would be a very serious problem because obviously treatment needs to be completed on these visits.

'There are real worries about the access for people from Gosport and these are of great concern.'

He added: 'The most alarming thing to me is that until county council members express concern, there had been virtually no co-ordination in looking into access for the hospital.'

The new working group has been in talks with all parties involved in access to the new hospital in the hope of ensuring there are no transport problems when it opens its doors.

Code A associate director performance at Portsmouth Hospitals Trust, said: 'We are making every effort to ensure that our patients are seen for their outpatient appointments within the community that they live.

'Any patients that have appointments at Queen Alexandra Hospital will be made aware well in advance in order for them to make suitable arrangements to attend their appointment.

'Work continues with public transport providers to improve public transport services to QA Hospital.'

WORLD-CLASS FACILITIES

Patients have been promised 'world-class facilities' once the £256m rebuild of Queen Alexandra Hospital is complete.

By June 15 all 3,500 rooms at the hospital are set to be finished.

All wards are being coated with antibacterial paint to minimise infection.

Even the specially-designed curtains contain an anti-microbial agent that keeps disease-causing bacteria at bay.

A new rehabilitation building complete with hydrotherapy pool, helipad, pathology and mortuary building and a £3m state-of-the art cancer lab funded by the hospital's Rocky Appeal are already up-and-running.

Majority verdict to be accepted in Gosport War Memorial inquests
Portsmouth Today, 17 April 2009

The coroner sitting in the case of the deaths of 10 elderly patients at Gosport War Memorial Hospital today told a jury he would accept a majority verdict from them.

Shortly before they retired to consider their verdicts for the second day, Code A told the five women and three men on the panel:

'Until now I wanted your decision to be unanimous.

'As of day two I will accept a majority decision - verdicts on which six of you must agree.'

The jury has to decide on a cause of death for each of the 10 and whether large doses of strong painkillers contributed to their deaths.

All 10 died on Dryad ward at the Bury Road hospital between 1996 and 1999.

Jury out in hospital deaths inquest
Press Association, 17 April 2009

An inquest jury began a second day of deliberations into the deaths of 10 elderly patients at a hospital amid allegations of over-prescribing painkillers.

The panel of five women and three men has spent four weeks at Portsmouth Coroner's Court looking at how the 10 died at the Gosport War Memorial Hospital in Hampshire more than 10 years ago.

The hearings needed special permission from Justice Secretary Code A because seven of the bodies have been cremated.

The inquest has heard that each of the 10 patients went to the community hospital for palliative care but died there.

The jury has heard evidence from the patients' families, medical experts and staff at the hospital, including Dr Code A

She is the only individual investigated by police in connection with deaths at the hospital but she was not charged with any offence.

Hampshire Police have carried out a series of investigations into the treatment of 92 patients at the Gosport War Memorial Hospital in the late 1990s but no action was taken.

The families of those who died believe that sedatives such as diamorphine were over-prescribed at the hospital and this led to the death of their relatives, who were receiving recuperative care.

But staff said that many of those who died were seriously ill.

Inquests are being held into the death of Code A from Gosport who died on September 26 1998; Code A on November 21 1999; Code A of Gosport, on November 22 1999 and Code A of Gosport, on August 21 1998.

Inquest on 10 deaths at hospital
Belfast Telegraph, April 16, 2009 Thursday

AN INQUEST jury retired today to consider its verdicts into the deaths of 10 elderly patients at a hospital

amid allegations of over-prescribing painkillers.

The panel of five women and three men has spent four weeks at Portsmouth Coroner's Court looking at how the 10 died at the Gosport War Memorial Hospital in Hampshire more than 10 years ago.

The hearings had to be given special permission by Justice Secretary Code A because seven of the bodies have since been cremated.

The inquest has heard that each of the 10 patients went to the hospital for palliative care but died while at the community hospital.

The jury has heard evidence from members of the patients' families, medical experts and staff at the hospital, including Dr Code A

Jurors deciding whether drugs caused deaths
Portsmouth Today, 16 April 2009

Eight jurors were today spending their second day sifting through piles of evidence in an attempt to reach verdicts in an unprecedented series of inquests.
The five women and three men at Portsmouth Crown Court retired yesterday morning with an avalanche of notes and documents gleaned from four weeks of listening to the details of the deaths of 10 hospital patients.

The 10 died at the Gosport War Memorial Hospital between 1996 and 1999.

Their ages ranged from 68 to 99, and most of their relatives have fought for 10 years to have these cases aired in public.

They took up the fight because they believe their loved ones died unexpectedly after being given high doses of powerful painkillers and sedatives.

Coroner Code A sent them out to start thinking about their verdicts at 10.10am yesterday.

As they filed from Court One in the Winston Churchill Avenue building they took with them sheaves of notes they had taken throughout the four weeks of the hearings.

As they left the room Code A said: 'I suspect they might be some time.'

But half an hour later they sent word that they wanted even more documents.

These were the patients' drug charts recorded on Dryad ward at the Bury Road hospital and copies of statements from various nurses that were read as evidence by Code A throughout the inquests.

Code A had to call them back into court to explain that they could have them but they would have to be copied. This took another hour.

The jury then retired again.

They are considering three questions on each of the 10 deaths.

The first is whether they consider the administration of any medication caused death.

If they believe the answer to that is 'yes' they then have to consider whether those drugs were given for theraputic purposes and whether they were appropriate for the condition from which the patient was suffering.

Dr Code A the Gosport GP who was also in charge of patient care on Dryad ward and around whom all 10 cases centre, was not present in court yesterday. She had been present throughout the case

(Proceeding)

Case into hospital deaths nears end

Pharmacy Europe, Thursday 16th April 2009

An inquest jury has retired to consider its verdict over allegations that the over-prescription of painkillers at a Hampshire hospital resulted in the deaths of 10 elderly patients.

The patients had gone to the Gosport War Memorial Hospital for palliative care but had died while at the community hospital, Portsmouth Coroner's Court heard.

The cremation of seven of the bodies meant the hearings had to be given special permission by justice secretary Code A

The panel of five women and four men heard evidence from medical experts, staff at the hospital and members of the patients' families.

A statement was also given by Dr Code A who worked at the hospital and was the only person to have been officially probed by police in connection with deaths. She was not charged with any offence.

The accusation by families of the deceased is that their relatives died because sedatives such as diamorphine were over-prescribed at the hospital. Staff denied this, saying many of those who died were seriously ill.

Hampshire Police have carried out a series of investigations into the treatment of 92 patients at the Gosport War Memorial Hospital in the late 1990s but no action was taken.

Jury retire to consider Gosport War Memorial deaths
Portsmouth Today, 16 April 2009

The jury has been sent out to consider their verdicts in the case of 10 deaths of elderly patients at a Gosport hospital.

Coroner Code A sent them to their room at Portsmouth Crown Court at 10.10am.

As they left the court he said: 'I suspect they might be some time.'

For the past four weeks they have been digesting a mountain of evidence in the 10 inquests.

They are considering verdicts on 10 elderly patients who died at Gosport War Memorial Hospital between 1996 and 1999.

No-one is on trial, inquest jury is warned
Portsmouth News, 16 April 2009

Jurors have been told they cannot point the finger of blame at any individual when they reach their verdicts on 10 deaths of elderly patients in a Gosport hospital.

Coroner Code A told them they were not concerned with finding anybody liable for the deaths at the War Memorial Hospital.

Summing up on the 18th day of the unprecedented inquests at Portsmouth Crown Court, Code A said the five women anADVERTISEMENTd three men on the jury would have to consider each case individually before returning verdicts simultaneously on all 10.

He told them they were 'the fact-finders' at the conclusion of the hearings which started on March 18.

Code A said their job was to establish from all the evidence they have heard how each patient died and not who, if anyone, might have been responsible.

Gosport GP Code A has featured in each of the 10 cases and her prescribing regime of strong painkilling drugs has been examined in minute detail.

Code A warned the jurors that no one was on trial in an inquest.

He said: 'This is not a trial of anybody, least of all Dr Code A You cannot, in any way, deal with liability.'

The coroner then spent the rest of yesterday reminding the jury of all the evidence concerning each of the 10 patients – all of whom died on Dryad ward at the War Memorial between 1996 and 1999.

He told them that when they retired to consider their verdicts they would have access to all records – including each patient's medical records and those of the War Memorial Hospital and of the hospital from which they were transferred.

Throughout the inquests not only has Dr Code A come under scrutiny, but also the actions of various nurses who were allowed to administer her prescriptions.

The hearings are examining the deaths of Code A

Code A

The jury was expected to be sent out today.

(Proceeding)

CRITICAL QUESTIONS

When coroner Code A asked the jury to retire today he was asking them to consider three questions on each of the 10 deaths.

The first question they had to consider was: did the administration of any medication contribute, even minimally, to the death of the deceased?

If they decided the answer to that question was 'yes', they had to move to the second question which asked: was that medication given for therapeutic purposes?

Again if the jurors decided the answer to that was 'yes' they were going to the third question which asked: was it (the medication] appropriate for the condition from which the deceased was suffering?

Jury out in hospital deaths inquest
The Press Association, 16 April 2009

An inquest jury has retired to consider its verdicts into the deaths of 10 elderly patients at a hospital amid allegations of over-prescribing painkillers.

The panel of five women and three men has spent four weeks at Portsmouth Coroner's Court looking at how the 10 died at the Gosport War Memorial Hospital in Hampshire more than 10 years ago.

The hearings had to be given special permission by Justice Secretary Code A because seven of the bodies have since been cremated.

The inquest has heard that each of the 10 patients went to the hospital for palliative care but died while at the community hospital.

The jury has heard evidence from members of the patients' families, medical experts and staff at the hospital, including Dr Code A

She was the only individual to be investigated by police in connection with deaths at the hospital but was not charged with any offence.

Hampshire Police have carried out a series of investigations into the treatment of 92 patients at the Gosport War Memorial Hospital in the late 1990s but no action was taken.

The families of those who died believe that sedatives such as diamorphine were over-prescribed at the hospital and this led to the death of their relatives, who were receiving recuperative care.

But staff said that many of those who died were seriously ill.

The inquests are being held into the deaths of Code A from Gosport, who died on

Code A

Jury goes out in patients inquest
BBC News Online, 16 April 2009

The inquest jury looking into the deaths of 10 patients at a hospital in Hampshire has retired to consider its verdict.

The five women and three men on the jury at Portsmouth Coroner's Court have heard about the deaths at the Gosport War Memorial Hospital a decade ago.

Over four weeks, the panel heard how the patients had gone to the hospital for palliative care and died there.

Justice Secretary Code A gave special permission for the hearings.

Series of investigations

The inquest was held into the deaths of A Code A

Code A

They died at the Gosport War Memorial Hospital (GWMH) between 1996 and 1999.

Some families claimed sedatives like diamorphine were over-prescribed at the hospital.

Hampshire Constabulary carried out a series of investigations into the treatment of a total of 92 patients at the hospital in the late 1990s, but no prosecutions have been brought.

The jury has heard evidence from members of the patients' families, medical experts and staff at GWMH, including Dr Jane Barton.

Dr Code A who was the primary clinician involved in the 10 cases, has been the only individual to be investigated but no charges were made against her.

Staff had concerns over drug machines
Portsmouth Today, 9 April 2009

A former senior nurse at the Gosport War Memorial told an inquest into 10 patient deaths that staff raised fears about the introduction of new painkilling machines.

Sister Code A said colleagues did not like the idea of having to operate syringe drivers.

These are pumps which are attached to a patient's body and automatically pump strong painkillers, such as diamorphine, into the body.

On the 16th day of inquests into the deaths of patients at the Bury Road hospital, a statement made by Mrs Hamblin to police in February 2003 was read to the jury at Portsmouth Crown Court.

In it she said the syringe drivers were introduced by Gosport GP Dr Code A in 1989 who was responsible for day-to-day medical care of the elderly on the Dryad ward.

Code A said staff worries over using the machine were so great that a series of meetings were held with managers.

She added: 'Some time in 1989 she introduced syringe drivers. At this time there were a number of concerns in the use of these.

'In 1991 concerns were expressed by the night staff about the use of syringe drivers and the lack of training available for using them.'

She said that meetings were arranged for nurses to voice their worries to senior managers and 'on-the-

job' training was arranged.

However, the inquests have been told previously that by 1996, when the first of the 10 deaths happened, staff were content to use the drivers.

In her statement - read by coroner Code A said she would always query a prescription made by Dr Code A if she thought the dosage was wrong.

She said: 'If I ever had a query with the drugs prescribed by Dr Code A I would say to her "hang on, is this right?"

'You would never just give it. You just wouldn't do it.'

Doctor denies killing patients
Portsmouth Today, 09 April 2009

A doctor has told an inquest into 10 deaths at the Gosport War Memorial Hospital that drug doses weren't deliberately increased to kill patients.
Dr Code A angry denial came at the end of several hours of close questioning by a barrister yesterday.

Code A went over the minute detail of Code A admission to Dryad ward and his death at the hospital on October 10, 1998.

Code A representing Code A son Code A took Dr Code A through the Code A admission to Queen Alexandra Hospital, Cosham, with a broken shoulder, to his transfer to the War Memorial and his death four days later.

Code A wanted to know why, when Code A had been treated with Paracetamol-based drugs at QA, he was suddenly given much stronger painkillers when he arrived at Gosport.

The inquest has already heard how he'd had to endure a four-hour ride in a hospital minibus to get from QA to Gosport.

Dr Code A told the jury considering the cases at Portsmouth Crown Court that she did not remember Mr Code A case specifically, but said: 'I'd imagine that after four hours in a hospital minibus he was in a great deal of pain.

'I would have felt that the level of analgesia he was getting at QA might not have been enough.'

She told the court that when he was admitted to the Gosport hospital she prescribed 20mg of morphine to relieve his pain.

The following day she increased that to 50mg of oral morphine, she told the court.

Code A reminded Dr Code A that two experts have told the inquests they considered these doses to be 'excessive'.

She told the court: 'I prescribed the appropriate level of morphine for his pain.'

She said she increased the dose on the second day of his time at Gosport because he had reacted well to the drug on his first night.

'The nursing records show he had a settled and comfortable night,' she said.

Code A who had severe alcohol problems, died from heart, kidney and liver failure.

But Code A asked Dr Code A if she had been aware in 1998 of the dangers of giving oral morphine to a patient with a serious liver condition.

'I was aware of the potential danger of using strong opioids on a patient with a diseased liver, but his condition outweighed the risk,' she said.

She then added: 'You are trying to imply that the doses were put up until the patient dies which is absolutely not true.'

(Proceeding)

WHAT HAPPENS NEXT

The unprecedented inquests into the 10 deaths at the Gosport War Memorial Hospital, between 1996 and 1999, are about to enter their final phase.

Today was the 16th day of the hearings in front of a jury of five women and three men. Coroner Code A Code A, who normally rules on deaths in north Hampshire, has said he will now take evidence only from written statements.

Code A has told the six barristers representing NHS staff and families of the 10 dead patients that he will hear legal submissions from them next Tuesday and will spend Wednesday and possibly part of next Thursday summing up.

At that point he will send out the jury to consider their verdicts – separate ones in each of the 10 cases.

'No defence' for excessive doses
Portsmouth Today, 06 April 2009

There was 'no defence' for giving elderly patients excessive doses of powerful drugs at Gosport's War Memorial Hospital, an expert told an inquest into their deaths.
Doctor Code A told an inquest he could find 'no justification' for the wide range of morphine and sedative doses prescribed to some patients at the hospital.

The expert - asked by Hampshire Constabulary to investigate the deaths of 10 people there - 'disagreed completely' with the pre-prescription of 20mg to 200mg of painkiller diamorphine to some patients.

Dr Code A said his own research on 100 elderly deaths showed the medium dose of the drug prescribed to them in the last 24 hours of life was just 40mg.

He also criticised poor note keeping by GP Code A then clinical assistant on now defunct Dryad and Daedalus wards where the patients died between 1996 and 1999.

He told the inquests, being held at Portsmouth: 'It doesn't defend what happened here. There is no defence. There is no justification- there is no obvious understanding as to why certain drugs were given in certain doses.'

The inquest earlier heard Dr Code A was too busy to keep accurate patient notes.

Dr Code A said: 'People can always say they are busy. It doesn't absolve you from doing a good job.

'Part of doing a good job is recording and documentation.'

The expert described the policy of pre-prescribing drugs to dying people as adopted by Dr Code A as 'good practice'.

However Code A said: 'But it should always be in the context of small, intermittent doses rather than pre-prescribing with a syringe driver (an automated pump to administer drugs] with a wide dose range.'

He added: 'The doses that are used are not informed. They are not based on what the patients key needs are.

'If you are dealing with more opioids than required its (effects are) then maybe confusion, respiratory depression and death.'

The unprecedented inquest is examining the deaths of Code A - known as Code A Code A

Code A

Proceeding.

'Drugs contributed to patient's death'

Excessive amounts of drugs given to an elderly woman at Gosport War Memorial Hospital contributed to her death, an inquest heard.

Expert Dr Code A said the doses of diamorphine prescribed to Code A at Gosport War Memorial Hospital played a part 'more than minimally, negatively or contribulatory to her death.'

The 92-year-old died on Dryad ward on April 13, 1999.

When Captain Code A visited his aunt there the day before she died she was unconscious.

The inquest earlier heard that consultant geriatrician Code A told Captain Code A had been given too much diamorphine but that the dose had been reduced.

Later that evening Captain Code A received a call to say his aunt had come round. Three hours later at 1.30am hospital staff called again to say Code A had died from a stroke.

Dr Code A added: 'Some of the drugs prescribed were difficult to justify."

He then said: 'It could have made her unresponsive.'

Doctor denies 'end of line' ward
BBC, 3 April 2009

A doctor at the centre of an inquest into 10 deaths at a Hampshire hospital has denied calling it "the end of the line" for patients, an inquest heard.

Dr Code A said she was referring to one patient only, Code A, who had been seriously ill and died at the Gosport War Memorial Hospital.

Inquests are being held at Portsmouth Coroner's Court into 10 deaths at the hospital more than 10 years ago.

Some families believe sedatives were over-prescribed at the hospital.

Code A was seriously obese with various medical problems, the court heard.

He was transferred to the hospital's Dryad Ward from the Queen Alexandra Hospital in Cosham. He died nine days later.

The family's lawyer, Code A said to Dr Code A "You said you couldn't remember any patients being transferred from Dryad Ward, which you described as the end of the line."

Dr Code A said: "Dryad was the end of the line for Code A because of his medical condition.

'Not rehab ward'

"It was not the end of the line because it was Dryad Ward."

Referring to the Dryad Ward, Dr Code A old the court that when very ill patients came in, they were often put into a room on their own for greater privacy and comfort.

She also said people were often sent there from other hospitals with the word "rehabilitation" on their notes, which she said was unrealistic.

"They wrote 'rehab' on the top but we were not a rehabilitation ward," she said.

Hampshire police carried out a series of investigations into the treatment of patients at the hospital in the late 1990s, but no prosecutions have been brought.

The inquests are being held into the deaths of Code A

Code A

The inquest continues.

Doctor denies that drugs given for pain caused death
Portsmouth Today, 03 April 2009

The doctor at the centre of the Gosport War Memorial Hospital inquests said yesterday the death of one of her patients was not caused by excessive medication.

GP Code A believes Code A – known as Code A died from a heart attack.

The Code A ar-old 'turned into a vegetable' after being admitted to the hospital, according to daughter Code A

He died on Dryad ward – where Dr Code A was clinical assistant at the time – on September 3, 1999.

Code A had taken only paracetamol prior to his admission, an inquest at Portsmouth heard.

But three days after his arrival, Dr Code A suspected Code A had suffered a heart attack or gastro-intestinal bleed and prescribed 10mg of oral morphine.

A dose of between five and 10mg is initially recommended for severe pain. He received 20mg that day and 60mg the following day.

Three days later a syringe driver – an automatic pump to administer medication – was started containing 40mg of painkiller diamorphine and 20mg of sedative midazolam over 24 hours.

On September 1, two days later, the dosage increased again.

Barrister Code A representing relatives, claims the increase in medication caused Mr Code A death.

He said: 'It was as a result of these final increases and his gastro-intestinal bleed that he died.'

Dr Code A eplied: 'No. Excuse me. You are suggesting that the dose of opiates that he received and the gastro-intestinal bleed caused his death and I'm suggesting in my opinion his condition, including a possible heart attack caused his death – not the dose of opiates.'

Code A deputy assistant coroner for Portsmouth and south-east Hampshire, had earlier told the jury: 'It certainly wouldn't be my view that is a lethal dose.'

Code A death is one of 10 at Gosport War Memorial Hospital being examined in an unprecedented inquest.

The others are Code A

Code A

All of the deaths occurred between 1996 and 1999.

(Proceeding)

92-year-old was only in hospital for 'rehabilitation'

A 92-year-old woman who had broken her hip died from a stroke at the Gosport War Memorial after

being admitted for rehabilitation, the inquest was told.

Dr Code A said when Code A was transferred from the Royal Hospital Haslar to the War Memorial she was taking only paracetamol to ease her pain. She told the jury that it became clear quickly that Code A 'was in a lot of pain'.

Dr Code A said the patient's notes said she had been sent to the hospital 'for rehabilitation and gentle mobilisation'.

But the GP said that because of Code A pain she decided to put her on a syringe driver which pumped stronger painkillers into her body. It was solely to relieve the pain and distress that Code A Code A was suffering,' said Dr Code A

Code A QC, who is representing Dr Code A reminded the doctor that earlier this week Mrs Code A nephew Code A had told the inquests he believed the cause of the fatal stroke could have been caused by the diamorphine.

'Can that happen?' he asked Dr Code A It is not suggested in any of the text books,' she replied.

Relative says care was 'inhumane'
Portsmouth Today, 02 April 2009

The care of an elderly woman who died at a hospital was 'inhumane', an inquest has been told.

Captain Code A claims his aunt Code A was treated as a 'useless part of society' by staff on Dryad ward at Gosport War Memorial Hospital.

And he told the jury he believed the 92-year-old died because she was given too much diamorphine.

When he visited his aunt for the last time the day before she died Code A was unconscious.

During evidence yesterday, Code A said consultant geriatrician Code A had informed him four hours after his arrival that Code A state was due to her being given too much diamorphine.

He told the inquest: 'Dr Code A informed me the only thing wrong with my aunt was that she had been given too much diamorphine.

'He then told me the dose had been reduced.'

Code A left and later that evening received a phone call to say his aunt had come round.

Three hours later – at about 1.30am on April 13, 1999 – he received a second call to say Code A had died from a stroke.

Code A said: 'This I believe was brought on by too high a dose of diamorphine.'

He added: 'I would like to know why the treatment of my aunt was so cavalier and would go so far as to say inhumane.

'And I would like to know why (my aunt] was treated as a useless part of society.'

Code A claims he did not have any contact with Dr Code A – then clinical assistant on the now defunct Dryad and Daedalus wards and at the centre of 10 patients deaths being examined by the inquest.

The other deaths being examined as part of the unprecedented inquest are those of Code A

Code A

All 10 deaths occurred at the hospital between 1996 and 1999.

(proceeding).

Doctor was struggling – consultant

The doctor at the centre of the Gosport War Memorial inquests was 'struggling to give patients enough care', a jury was told.

Consultant geriatrician Code A said Dr Code A - former clinical assistant at the War Memorial – was finding it difficult to sustain her workload at the time he arrived on now defunct Dryad and Daedalus wards in 1999.

He said: 'I think she was struggling to give patients enough care. It was getting very difficult for her to maintain.

'I think it was only by cutting things like note keeping that she was able to see patients and do what she could for them.'

Dr Code A said some people were given 'unrealistic expectations' about relatives' hopes of recovery. He said: 'We certainly came across people who had been set totally unrealistic expectations from other wards.'

He said some patients were told: 'We will get you up on your feet in no time at all,' adding, 'in some patients it would be a realistic assessment. In others it wouldn't be.'

However when asked about Dr Code A pre-prescription of between 20mg and 200mg of diamorphine a day to some patients, he said: 'That would be very unusual and I would expect to see justification for that prescription in the medical notes.'

Daughter says she watched dad 'turn into a vegetable'
Portsmouth Today, 01 April 2009

The daughter of a man who died at Gosport War Memorial Hospital told a jury how her father 'became a vegetable' three days after he was admitted.
Code A said her dad, Code A known as Code A went from being 'chatty and cheerful' to being 'away with the fairies'.

Code A was giving evidence on the tenth day of inquests probing 10 deaths at the Bury Road hospital between 1996 ADVERTISEMENTand 1999.

She told a jury her father, who died at the age of 66 in September 1999, had been admitted to Queen Alexandra Hospital, Cosham, for treatment to swollen feet and legs.

But she said he was transferred to the War Memorial after a couple of weeks 'for rehabilitation and remobilisation'.

She told the court: 'When I first visited him at Gosport he was sitting up in bed, eating and drinking properly and was in good spirits.

'But after three or four days there he seemed to be spaced out. He appeared very sleepy. The change was dramatic.

'When my dad went to Gosport he was fine. He was chatty and cheerful and full of beans. Three days later he was away with the fairies.

'He became a vegetable and just slept. He drifted in and out of consciousness. He was completely out of it.'

Other families have told the hearings that their relatives died unexpectedly after being given high doses of powerful painkillers and sedatives.

>>> Follow live coverage of the inquest. Click here.

Code A said that three days after her father was admitted to the War Memorial her mother got a phone call to say he had suffered a heart attack.

She told the jury: 'When we arrived to see him he told us he had had a bad case of indigestion – something he suffered with all his life.'

Code A said her mother was then called into a room by Dr Code A the clinical assistant and Gosport GP at the centre on the inquests.

'She told her very bluntly he was going to die,' she said.

Code A who lived at Emsworth and was a former leader of the TS Unity sea cadet corps in the town, died eight days later.

(Proceeding)

ELDERLY MAN MIGHT HAVE SURVIVED

An elderly man might have survived had he not been given morphine on admission to a hospital, according to an expert.

In a statement read out at the inquests into 10 patient deaths at Gosport War Memorial Hospital, Professor Code A described the prescription of opiate drugs to Code A on his admission to Dryad ward as 'inappropriate'.

The 74-year-old died four days after being admitted, on October 18, 1998.

Alcoholic Code A was given strong doses of morphine and then diamorphine through a syringe driver – an automatic pump for administering drugs – before he died.

In a statement read out by Code A, the deputy assistant coroner for Portsmouth and south-east Hampshire, Prof Code A wrote: 'Code A did fall into the category of patients who might have left hospital alive if he had not been commenced on opiate medication on transfer to Dryad ward.'

'My mother was given a cocktail of drugs'

A daughter told of her shock at discovering the cocktail of drugs her mum was given in the last days of her life.

Code A pictured below, did not learn the truth about drugs prescribed to Code A until she received her medical notes about three years after the 88-year-old's death.

Code A was given a 25-microgramme-patch painkiller Fentanyl three days before she died on Dryad ward, an inquest heard. The next day the widow received 40mg of diamorphine – four times above the recommended starting dose – and 40mg of the sedative midazolam.

But the patch was not removed for three-and-a-quarter hours, meaning Code A received a 'substantial overdose', the jury heard.

She was also given chlorpromazine – not recommended for use with midazolam due to potential side effects.

Code A died on November 21, 1998.

Daughter Code A said she was never told she was being given a syringe driver – an automated pump for administering drugs – or that she was being prescribed diamorphine.

She told the inquest: 'I was shocked to see the cocktail of drugs that my mother had been administered in the last four days of her life.'

Son accused doctor of murdering relative
Portsmouth Today, 28 March 2009

A RELATIVE of a man who died at Gosport War Memorial Hospital told an inquest how he accused a doctor of murder.
Code A said he confronted Dr Code A when he discovered his step-father Code A Code A was dying.
He told a jury he believed the 79-year-old had been 'intentionally executed' by staff at the hospital.
Giving evidence at PortsmoutADVERTISEMENTh Crown Court yesterday, Code A said his step-father – a former Second World War fighter pilot who suffered from Parkinson's disease – had gone into the hospital to have a severe bed sore treated.
The inquest heard how Code A had been put on a machine called a syringe driver – which automatically pumps painkilling drug diamorphine into the body. Code A believes this caused his step-father's death five days after being admitted to the Gosport War Memorial.
Code A told the court he had been trying to see Dr Code A for several days to discuss the treatment but had been told she was unavailable.
He said he and his wife were at the hospital during Code A final hours.
'My wife and I remained at the hospital with Code A and while we were waiting Dr Code A finally made an appearance,' he said. 'I accused Dr Code A of murdering Code A and the interview was rapidly terminated.'
Code A the barrister representing Dr Code A at the hearings, accused Mr Code A of being 'irrational'.
He said: 'You have accused Dr Code A of murder and it seems she brought the conversation to a close.
'Will you accept that there is not much to be said if one party considered you to be irrational?
'You were then and you are now.'
Mr Code A had earlier explained what happened the day his step-father was admitted – September 21, 1998.
He said: 'I went to see Code A and was told by staff he was on the Dryad ward. During this exchange a male member of staff said "that is the death ward".
'I thought that was an utterly irresponsible thing to say.'
When he saw his step-father he said he was 'absolutely shocked' to see him unconscious and on a syringe driver.
'I understood the implication immediately,' Code A told the inquest, which is probing the deaths of 10 patients at the hospital between 1996 and 1999.
'I was utterly appalled and asked for the syringe driver to be stopped. This was refused.'
A nurse told Code A only a doctor could remove the syringe driver, the inquest heard.
'I was convinced Code A was being intentionally executed,' Code A said.
(Proceeding)

Managers 'ignored concerns' over plans to increase patient numbers
BBC Online, 27 March 2009

The doctor responsible for looking after elderly people at the Gosport War Memorial Hospital quit her role in a row over patient care, the inquest heard.
Dr Code A resigned as clinical assistant in July 2000 after 12 years in the post.

Taking the stand for the first time, she said NHS managers wanted staff in Dryad and Daedalus wards to take on more complex patients to ease bed-blocking at acADVERTISEMENTute hospitals including Queen Alexandra, Cosham.

A senior manager wrote in a letter to Dr Code A and other staff that some surgeries had to be cancelled due to overwhelming demand.

Dr Code A raised concerns about the added pressure this would place on already stretched staff but, she claims, her fears were ignored. She said it would 'inevitably lead to further serious and damaging complaints about the service given in my wards'.

Dr Code A added that the hospital was struggling to cope with 40 per cent of continuing care patients in Portsmouth and south-east Hampshire.

The inquest into the deaths of 10 patients in the now defunct Dryad and Daedalus wards between 1996 and 1999 heard Dr Code A was a full-time GP as well as clinical assistant at the hospital.

She was regularly expected to see and review up to 40 patients between 7.30am and 8.45am five days a week at that time.

She then fulfilled her general practice duties but would often return to the hospital at lunch times, evenings and weekends, the jury heard. She also took calls at home.

By 1998 the wards were operating at about 80 per cent capacity but managers wanted to increase this to 90 per cent.

Inquest hears man was 'executed'
BBC Online, 27 March 2009

Code A died while being treated at the hospital
A man has told an inquest he believes his step-father was "intentionally executed" while at hospital.

Code A was admitted to Gosport War Memorial Hospital in 1998 with serious bed sores, jurors heard.

His step-son told jurors a staff member said his father was on the "death ward" just days before he died after being given increased doses of diamorphine.

Inquests are being held at Portsmouth Coroner's Court into the deaths of 10 hospital patients over 10 years ago.

Code A who was also known as Code A was admitted on 21 September, 1998.

On the first day of his admission he became agitated with nurses and started taking off the dressing to his wound, the hearing has heard.

The inquest heard he was given a 10mg morphine tablet, but he remain agitated.

Jurors were told later in the night he became sedated and unable to take his usual medication and he was connected to a syringe driver and given 20mg of diamorphine - two to three times stronger than morphine.

I was absolutely shocked to see Code A unconscious and on a syringe driver.

Code A

Diamorphine was then increased four-fold over the following days before he died, jurors were told.

Code A step-son, Code A said: "I went to see Code A and told he was on the Dryad ward.

"During this exchange a male member of staff said 'that is the death ward'.

"I thought that was an irresponsible thing to say."

When he saw his relative he said he was "absolutely shocked to see Brian unconscious and on a syringe driver".

"I understood the implication immediately," Code A added.

Code A said her concerns about diamorphine were resolved by 1996

"I was utterly appalled and asked for the syringe driver to be stopped...this was refused."

A nurse told Code A only a doctor could remove the syringe driver, the inquest heard.

"I was convinced Code A was being intentionally executed," Code A told jurors.

The hearing also heard on Friday from Code A who was a nurse at the hospital.

She told the hearing she raised concerns over the use of diamorphine in 1991.

Jurors heard she was worried about the way it was administered, that it could cause harm and potential death.

She was told a policy was going to be drawn up but she saw no evidence of this, jurors heard.

But she told the coroner that in 1996, the year of the first of the 10 deaths, the issue surrounding diamorphine had been resolved.

Hampshire police carried out a series of investigations into the treatment of patients at the hospital in the late 1990s, but no prosecutions have been brought.

The inquests, expected to last six weeks, are being held into the deaths of Code A

Code A

The inquest was adjourned until Monday.

Inquest hears nurse's painkiller concerns
Nursing Times, 25 March, 2009

An inquest into the deaths of 10 patients at a Hampshire hospital has heard from a senior nurse who said she raised concerns about how painkillers, such as diamorphine, were being prescribed at the hospital.

Code A a senior staff nurse at Gosport War Memorial Hospital (GWMH), said she was worried that analgesic medicines were being administered prematurely and said that the analgesic ladder, which lays out how dosage and types of painkillers should be increased incrementally, was not being adhered to.

However, Code A concerns were made in 1991 and the guidelines were changed before the first death being examined in 1996.

The coroner, Code A, asked Code A if she would have raised the issue again after 1996 if she still had concerns.

She said: 'If I was uncomfortable I would have said so and I would not have administered the painkillers.'

Tom Leeper, who is representing four of the families, asked the nurse if at any time in 1991 she had concerns that deaths were sometimes hastened unnecessarily.

She responded: 'I do not recall.'

Inquests are being held at Portsmouth Coroner's Court into the deaths of the 10 patients at GWMH more than 10 years ago and are expected to last six weeks.

Drugs overdose was substantial, inquest jury told
Portsmouth Today, 26 March 2009

AN elderly woman received a 'substantial overdose' at a hospital days before her death, an inquest heard.

Code A was given a cocktail of drugs – all above the recommended dosage – at Gosport War Memorial Hospital, the jury was told.

The 88-year-old was given a 25microgramme patch of painkiller Fentanyl, three days before she died.

The following morning she was given 40milligrammes of diamorphine – four times more than the recommended starting dose – and 40mg of sedative Midazolam. Both were administered through a syringe driver, which automatically pumps the drug into the body.

However, the Fentanyl patch was not removed for a further three-and-a-quarter hours, meaning Mrs Code A was receiving a 'substantial overdose' during that period, the inquest heard.

Code A assistant deputy coroner for Portsmouth and south-east Hampshire, said: 'The point is that there is a substantial increase in the dose in that period.

'It is not just a marginal overdose, it is a substantial overdose.'

Code A was also given 50mg of chlorpromazine – between two and four times the maximum recommended dose for elderly patients.

It is also recommended that the drug is not mixed with Midazolam due to potential side effects.

Code A died on the Dryad ward 58 hours later on November 21, 1999.

Giving evidence, Professor Code A who was called in by Hampshire police to examine patient deaths at the hospital, told the inquest: 'It was possible that her more rapid deterioration was due to the use of Fentanyl on top of her other medical conditions.'

Prof Code A also raised concerns about the levels of medication given to Code A prior to her death.

He added: 'I remain concerned about the levels that were given and I would want to see and hear the justification for it.

'That's what I can't tell from the notes.'

Code A death is among 10 being examined as part of an unprecedented inquest being held in Portsmouth.

The other deaths being examined are those of Code A

Code A

All patients were treated on the Dryad or Daedalus wards and died at Gosport War Memorial Hospital between 1996 and 1999.

Morphine-induced coma cannot be ruled out – expert
Portsmouth Today, 26 March 2009

The possibility that an elderly man died from a coma caused by the prescription of morphine cannot be excluded, a medical expert said.
Professor Code A told the inquest of his concerns that Code A was given oral morphine on admission to Gosport War Memorial Hospital.

The 74-year-old, who had severe alcohol- related liver disease, had been treated successfully with paracetamol and pain killer codeine phosphate, as well as five small doses of morphine, at Queen Alexandra Hospital, Cosham, before his transfer there.

However on arrival at the Bury Road hospital on October 14, 1998, medics decided he should be given oral morphine.

Code A was given 20mg of the drug that day, followed by 50mg a day later.

By October 16 he had rapidly deteriorated.

Code A was short of breath, unresponsive and his arms and legs were swollen.

That day he was given 30mg of oral morphine and 40mg of Diamorphine through an automatic pump.

He died two days later on October 18.

Professor Code A told the inquest: 'I find it difficult from the notes to understand why he was not written up for the analgesia that he was receiving in (QA] but I can find no evidence as to why he was given strong opiates without that oral analgesia being written up and tried.'

He said he could find no justification for the drugs Code A was prescribed in his medical notes.

He added: 'I think my concern is understanding his rapid deterioration after admission to Gosport.'

Doctor 'warned of care pressures'
BBC Online, 26 March 2009

A doctor at the centre of a jury inquest into 10 deaths at a Hampshire hospital has said there were ever-increasing work pressures put on staff.

Dr Code A was giving evidence for the first time about the events at Gosport War Memorial Hospital (GWMH) between 1996 and 1999.

Dr Code A was responsible for the care of the 10 patients and the prescribing of their pain medication.

She said she had raised concerns about the workload with her health managers.

Dr Code A told jurors managers were sending more and more seriously ill patients to the hospital because of a bed blocking crisis at the local general hospital.

I could have said I couldn't do the job anymore and walked away

Dr Code A

Jurors heard Dr Code A, a GP, worked part time at GWMH for about 90 minutes a day, looking after 40 patients.

She said that during the 1990s she saw a greater number of patients, with increasingly serious conditions.

"I raised the issue, saying I couldn't manage this level of care," she told the inquest.

"But of course there was no-one else to do it.

"I could have said I couldn't do the job any more and walked away, but if I did, I felt I'd be letting down the staff and more importantly my patients."

'Damaging complaints'

She said that as a result of the pressures, her medical notes were sometimes "sparse" and that she started a system of "pro-active prescribing" - where prescriptions could be written in advance.

The medication could then be given to patients by nurses when they needed it, she said.

Dr Code A resigned in April 2000 shortly after telling health managers that the growing number of seriously ill patients being admitted would "lead to further serious and damaging complaints about the service given in my wards", jurors heard.

She was replaced by a full-time doctor.

Hampshire Police carried out a series of investigations into the treatment of patients at the hospital in the late 1990s, but no prosecutions have been brought.

Earlier on Thursday, the inquest heard an elderly man's final words to his son were that staff at the hospital were "killing" him.

Code A was admitted to GWMH in 1998 after suffering a broken arm.

His son, Code A said that at first his father, who also had liver problems, had been quite poorly - but had seemingly recovered quickly - before he was transferred to GWMH on 14 October, 1998.

But when Code A visited his father the following day, he said he had deteriorated severely and died days later.

The inquest heard that Code A was administered the painkiller diamorphine through a syringe driver from 16 October.

His son said he was not informed by staff why the syringe driver was being used and he believed the drugs had caused his father's condition to change.

The inquests, expected to last six weeks, are being held into the deaths of Code A

Code A

'They're killing me' said hospital patient
Portsmouth Today, 26 March 2009

An elderly man who died at Gosport War Memorial Hospital said in his final words that the staff were killing him, an inquest has heard.
Code A was admitted to the hospital in October 1998 after he had suffered a broken arm.

The 74-year-old also suffered from liver problems because of a long-standing heavy drink problem, the Portsmouth inquest heard.

His son Code A told the hearing that his father, who had served in the Royal Navy, had initially been admitted to the Queen Alexandra Hospital in Portsmouth having suffered a fall at his home in Sarisbury Green.

At first he was quite poorly, according to Code A but had made an "immense" recovery before he was transferred to GWMH on October 14, 1998, where he died four days later.

But when he visited his father the following day, Code A said he had deteriorated severely.

Code A from Gosport, said: I leant down to give my dad a cuddle and he spoke his very last words to me and he said: 'Help me son, they are killing me.'

'I said 'no they are not dad, they are trying to do their best for you' and I left him there. When I went in the following day he was in a coma.'

The inquest heard that Code A was administered the painkiller diamorphine through a syringe driver from October 16.

But his son said that he was not informed by staff why the syringe driver was being used. The inquest has heard that Code A died of heart failure as well as renal and liver failure.

The hearing continues.

Father claimed 'staff killing me'
BBC Online, 26 March 2009

An elderly man's final words to his son were that staff at a hospital were "killing" him, an inquest has heard.

Code A was admitted to the Gosport War Memorial Hospital (GWMH) in 1998 after suffering a broken arm.

Code A who also had liver problems due to a long-standing drink problem, had made an "immense recovery" but died four days later, the inquest heard.

Inquests are being held at Portsmouth Coroner's Court into the deaths of 10 hospital patients over 10 years ago.

Code A son, Code A, told the hearing that his father, who had served in the Royal Navy, had initially been admitted to the Queen Alexandra Hospital in Portsmouth having suffered a fall at his home in Sarisbury Green.

At first he was quite poorly, according to Code A but had seemingly recovered quickly, before he was transferred to GWMH on 14 October, 1998.

But when he visited his father the following day, Code A said he had deteriorated severely and he died days later.

Code A from Gosport, said: "I went to give him a cuddle and he spoke his last words to me: 'Help me son, they are killing me.'

"I said 'No they are not dad, they are trying to do the best for you' and I left him there.

"When I went in the following day, he was in a coma."

Code A told the inquest that staff at the hospital had refused to keep him informed of his father's condition because he was not the designated family member.

He added that because of rifts in the family, it had been difficult for him to find out about his father's condition.

Code A admitted: "I kicked off because I was excluded because I was not the designated family member and I was threatened with being evicted from the hospital."

The inquest heard that Code A was administered the painkiller diamorphine through a syringe driver from 16 October.

But his son said that he was not informed by staff why the syringe driver was being used.

Code A said: "I think it is because of the drugs that his condition changed."

The inquest has heard that Code A died of heart failure as well as renal and liver failure.

Hampshire police carried out a series of investigations into the treatment of patients at the hospital in the late 1990s, but no prosecutions have been brought.

The inquests, expected to last six weeks, are being held into the deaths of Code A

Code A

Inquest into 10 deaths at hospital 'that over-used painkillers'
The Daily Telegraph (London), March 19, 2009 Thursday

THE deaths of 10 elderly patients at a hospital at the centre of an investigation into the alleged over-use of painkillers are to be examined at an inquest.

The 10 were among 92 deaths at Gosport War Memorial Hospital investigated by police, but no prosecutions were ever brought.

As well as the police investigation, an inquiry was held by the Commission for Health Improvement (CHI), which criticised prescribing practices at the hospital.

As the inquest opened yesterday, the families of those who died at the hospital in Hampshire a decade

ago said they hoped the hearing would "get to the truth".

They have fought for the deaths to be fully investigated, believing that there has not yet been a satisfactory explanation.

The inquest in Portsmouth heard that Dr Code A the clinician "primarily involved", would be among those giving evidence at the six-week hearing. She was the only individual to have been investigated by police in connection with the deaths, but was not charged with any offence.

Code A who is representing four of the 10 families, said before the hearing that the allegations were "of the most serious kind".

"Several investigations have now taken place over many years but none has so far managed to get to a resolution.

"Given the time that has elapsed and the mass of information, I think the coroner will have a very difficult task but with our work and the efforts of the families I hope that he will get to the truth."

Code A the coroner, said Code A the Justice Secretary, had given special permission for the hearing because seven of the bodies had been cremated.

He said each of the 10 patients had gone to the hospital for palliative care. The jury's task was to reach a verdict on how the 10 patients died, but it was not to attribute liability for the deaths to any individual.

As well as the police investigation and CHI inquiry, the Government's chief medical officer, Sir Code A Code A also commissioned a clinical audit to examine death rates at the hospital in 2002.

Code A a professor of clinical governance who worked on the Code A inquiry, was appointed to the task but his results have not been made public.

Code A told the hearing that Prof Code A report would not be included in the inquest evidence but said it would be made available to the families after the hearing.

The inquests are being held into the deaths of Code A

Code A

The hearing continues.

PA Regional Newswire of English Regions: SOUTH EAST

March 19, 2009 Thursday 12:52 PM BST

HOSPITAL GAVE DEATH NEWS COLDLY, SON CLAIMS

SECTION: PA Regional Newswire for English Regions

LENGTH: 368 words

The son of a patient who died at a hospital in Hampshire has told of his shock at his mother's rapid deterioration while receiving rehabilitative care after suffering a stroke.

Inquests are being held at Portsmouth Coroner's Court into the death of 10 patients at the Gosport War Memorial Hospital (GWMH) more than 10 years ago.

Code A a widow from Gosport, suffered a stroke in early 1996 and was initially treated at the Royal Naval Hospital Haslar before being transferred to the GWMH on February 22, 1996.

The 83-year-old suffered from diabetes for 50 years and, as well as the stroke, she suffered a head

injury in a fall down the stairs at her home.

Her son Code A told the inquest that he understood that his mother was transferred to Daedalus stroke rehabilitation ward at GWMH for rehabilitative care but was shocked when Dr Code A told him in a ``callous'' manner that his mother ``had come to the hospital to die''.

Hampshire Police have investigated treatment of 92 patients at the hospital in the late 1990s but no prosecutions were brought by the Crown Prosecution Service. Their families believe that sedatives such as diamorphine were over-prescribed at the hospital and led to the death of their relatives who were receiving recuperative care.

As well as the police investigation, an inquiry was held by the Commission for Health Improvement (CHI) which criticised prescribing practices at the hospital.

Dr Code A who was the primary clinician involved in the 10 cases, has been the only individual to be investigated but no charges were made against her.

The inquests, expected to last six weeks, are being held into the deaths of Code A

Code A

The other deaths are of Code A

Code A

Press Association Newsfile

March 19, 2009 Thursday 11:38 AM BST

HOSPITAL GAVE DEATH NEWS COLDLY, SON CLAIMS

BYLINE: Code A Press Association

SECTION: HOME NEWS

LENGTH: 1075 words

The son of a patient who died at a controversial hospital today told of his shock at his mother's rapid deterioration while receiving rehabilitative care after suffering a stroke.

Inquests are being held at Portsmouth Coroner's Court into the death of 10 patients at the Gosport War Memorial Hospital (GWMH) more than 10 years ago.

Hampshire police have carried out a series of investigations into the treatment of 92 patients at the Hampshire hospital in the late 1990s but no prosecutions were brought by the Crown Prosecution Service.

Their families believe that sedatives such as diamorphine were over-prescribed at the hospital and led to the death of their relatives who were receiving recuperative care.

As well as the police investigation, an inquiry was held by the Commission for Health Improvement (CHI) which criticised prescribing practices at the hospital.

Code A a widow from Gosport, suffered a stroke in early 1996 and was initially treated at the Royal Naval Hospital Haslar before being transferred to the GWMH on February 22, 1996.

The 83-year-old had suffered from diabetes for 50 years and as well as the stroke, she had suffered a head injury in a fall down the stairs at her home.

Her son Code A told the inquest that he understood that his mother was transferred to Daedalus

stroke rehabilitation ward at GWMH for rehabilitative care.

But he added that he was shocked when Dr Code A told him in a ``callous" manner that his mother ``had come to the hospital to die".

He said that he had asked Dr Code A when his mother would be able to return home as they had to make arrangements concerning her cat.

He said that Dr Code A had replied: ``You can get rid of the cat. Do you know your mother has come here to die."

Code A added: ``I was shocked at the way this was said to me. I did not know that to be the case, I thought she had gone into the hospital for rehabilitation.

``I couldn't believe the cold way the news had been broken to me, as if it was pre-determined, I was shocked."

Dr Code A who was the primary clinician involved in the 10 cases, has been the only individual to be investigated but no charges were made against her.

Code A was to die at the hospital on March 6, 1996, with the cause of death stated to be a stroke.

Code A said: ``I am concerned at the rapid deterioration of my mother when she went into Gosport War Memorial Hospital.

``I accept she was an elderly lady however she appeared to be making a full recovery from a stroke. She was strong and lucid."

Code A representing Dr Code A suggested that the severity of his mother's condition was explained to him during the course of several conversations.

Code A replied: ``It is hard to recall exactly what happened but I have described it as it appeared to me."

The inquests, expected to last six weeks, are being held into the deaths of Code A

Code A

The other deaths are of Code A

Code A

Code A also said he could not recall being told by Dr Code A or staff at the hospital that a syringe driver would be put in place to provide his mother with painkilling medication diamorphine.

A syringe driver is a battery-powered device to provide injections over a period of time.

He said this was only explained to him after he saw it was being used.

Code A a retired ward sister who worked on Daedalus ward at GWMH at the time of Mrs Code A death, said that she could not remember Code A

But Code A who retired in 1997, explained that it was normal practice for the family of a patient to always be informed before a syringe driver was set up.

She said: ``If a patient's condition was deteriorating and they had to have a syringe driver put up, Dr Code A or I would always explain why a syringe driver would be put up.

``We would never put a syringe driver up without the family agreeing to it."

She added that it was practice on the ward for Dr Code A to write a prescription for larger doses of painkillers such as diamorphine so that their medication could be increased up to a set level without delay.

She said: ``When necessary, patients could be written up [prescribed] prior to it being given to prevent their pain as quickly as possible but it wasn't done on a regular basis."

She added that the dosage of medication would only be increased if the patient was obviously in pain.

She said: ``We would never increase it unless it was absolutely necessary."

She explained that this method of advanced prescription was put in place because of a shortage of doctors.

The inquest heard that Daedalus ward only had a doctor present for one hour a day on weekdays alone.

Code A said that if they had not had advanced prescriptions, a doctor would have had to have been brought into the hospital each time a patient's condition deteriorated.

Code A added that although Daedalus was a ward for stroke rehabilitation, not all patients transferred there were suitable for such care.

She explained that sometimes patients were placed at Daedalus to prevent ``bed-blocking" at other major hospitals in the area.

Code A suggested to Ms Joines that occasionally relatives had ``unrealistic expectations" of the patient's ability to recover.

Code A replied: ``Sometimes the patient's relative was told they were being sent to Daedalus for rehabilitation and this caused problems because we could see this wasn't the case."

She also defended Dr Code A who she worked alongside for nine years.

She said: ``I always found her to be very compassionate, very open with patients and patients' relatives.

``She was a caring doctor - her patients' welfare was all that she strode to achieve.

``I have had no objections for working for her, I admire her as a doctor and I had no reservations at the treatment she asked me to give over the years.

``I have never, ever heard her speak to a patient as Code A described how she spoke to him, she was always very professional."

The hearing was adjourned to tomorrow.

Daily Echo (Newsquest Regional Press)

March 18, 2009 Wednesday

Inquests open into ten hospital deaths

SECTION: LATEST NEWS (DE LATESTNEWS)

LENGTH: 474 words

TEN Hampshire families are hoping their elderly relatives who died a decade ago can finally be put to rest following an unprecedented set of inquests, starting today.

All the elderly people were patients at the Gosport War Memorial Hospital who died unexpectedly after being given high doses of sedatives and painkillers.

The Justice Secretary Code A granted the hearing last year, despite the fact that seven of the deceased have already been cremated.

Relatives of 92 patients who died at the community hospital during '90s have fought ever since for the matter to be properly investigated, believing their relatives' deaths were never properly explained.

Code A daughter of Code A who died at the hospital in November 1998 aged 88, said: "I want justice for my mother.

But I also want transparency, so we can find out what happened.

"It has taken ten years, but people are finally taking notice."

Code A a solicitor from Code A the firm representing four of the ten families, said: "The allegations in this case are of the most serious kind.

Several investigations have taken place but none has managed to get a resolution.

"Given the time that has elapsed and the mass of information, I think the coroner will have a very difficult task."

The deaths have already been the subject of a criminal investigation, dubbed Operation Rochester, which concluded that there is not enough evidence to charge anyone over the deaths.

Government inspectors criticised the community hospital in 2002 for its excessive use of pain-relieving and sedative drugs. Inspectors found there was no effective monitoring of the levels of prescription medicines and that some patients were prescribed strong pain relief before being properly assessed.

Dr Code A the only doctor to be investigated in relation to the case, was ordered to stop prescribing morphine last July.

Dr Code A who will give evidence at the inquests, will be the subject of a fitness to practice hearing later this year.

The inquests, listed together and scheduled to last six weeks, will be heard by the north east Hampshire coroner Code A sitting with a jury, at Portsmouth Combined Court.

Gosport MP Sir Code A has criticised the decision to hold a coroner's inquiry. Pointing out that the police had decided no action was required, Sir Code A said the issue should be "allowed to rest".

The listed inquests

Code A

INQUEST INTO DEATHS OF 10 ELDERLY PATIENTS
Press Association Newsfile, March 18, 2009

A jury was sworn in today at an inquest being held to probe the deaths of 10 elderly patients at a hospital which has been investigated by police for allegations of over-prescribing painkillers.

Coroner Code A told the panel of five women and four men that the hearing was to find out how the 10 patients of the Gosport War Memorial Hospital died more than 10 years ago.

He explained that the joint inquest being held at Portsmouth Coroner's Court had to be given special permission by Justice Secretary Code A because seven of the bodies had since been cremated.

The hearing, which is expected to last six weeks, was also told that only one of the patients had undergone a post-mortem examination.

Code A explained that each of the 10 patients had gone to the hospital for palliative care but had died while at the community hospital.

Code A told the jury that it would hear evidence from members of the patients' families, medical experts and staff at the hospital.

Among those to give evidence will be Dr Code A the only individual to have been investigated by police in connection with deaths at the hospital but who was not charged with any offence.

Code A said: ``During the relevant time, Dr Code A was the clinician primarily involved."

He explained to the jury that its task was to reach a verdict on how the 10 patients died but not to attribute liability for the deaths on any individual.

Hampshire Police have carried out a series of investigations into the treatment of 92 patients at the Gosport War Memorial Hospital in the late 1990s.

Their families believe that sedatives such as diamorphine were over-prescribed at the hospital and led to the death of their relatives who were receiving recuperative care.

As well as the police investigation, an inquiry was held by the Commission for Health Improvement (CHI) which criticised prescribing practices at the Hampshire hospital.

The Government's Chief Medical Officer, Sir Code A also commissioned a clinical audit to examine death rates at the hospital in September 2002.

Code A a professor of clinical governance who worked on the Shipman inquiry, was appointed to the task but his results have not been made public.

Code A told the hearing that Prof Code A report would not be included in the inquest evidence but said it would be made available to the families after the hearing was concluded.

He said: ``Because the report is too directional and to avoid finger-pointing and issues of liability, I do not want it to be introduced in these proceedings."

Hampshire Police referred the results of its inquiry in relation to some of the deaths to the Crown Prosecution Service (CPS), which decided not to prosecute.

Code A who is representing four of the 10 families, said ahead of today's hearing: ``The allegations in this case are of the most serious kind.

``Several investigations have now taken place over many years but none has so far managed to get to a resolution.

``We have asked the Ministry of Justice to fund our representation because of the wider public interest issues.

``Given the time that has elapsed and the mass of information, I think the coroner will have a very difficult task but with our work and the efforts of the families I hope that he will get to the truth."

Sir Code A, Conservative MP for Gosport, said that the inquest should not be held as sufficient inquiries had already been held into care at the hospital.

He said: ``There have been so many inquiries, there was a police inquiry that came to a conclusion that no further action was required.

``I like and know the hospital and the people there, and would like the issue to be allowed to rest."

But Code A leader of Hampshire County Council, said a public inquiry and not an inquest would be the only way of establishing all of the facts in relation to the deaths.

The inquests are being held into the death of Code A

Code A

The other deaths are of Code A

Code A

Code A

INQUEST INTO DEATHS OF 10 ELDERLY PATIENTS
PA Regional Newswire of English Regions: SOUTH EAST, March 18, 2009

A jury has been sworn in at an inquest being held to probe the deaths of 10 elderly patients at a Hampshire hospital which has been investigated by police for allegations of over-prescribing painkillers.

Coroner Code A told the panel of five women and four men that the hearing was to find out how the 10 patients of the Gosport War Memorial Hospital died more than 10 years ago.

He explained that the joint inquest being held at Portsmouth Coroner's Court had to be given special permission by Justice Secretary Code A because seven of the bodies had since been cremated.

The hearing, which is expected to last six weeks, was also told that only one of the patients had undergone a post-mortem examination.

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Among those to give evidence will be Dr Code A the only individual to have been investigated by police in connection with deaths at the hospital but who was not charged with any offence.

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Hampshire Police have carried out a series of investigations into the treatment of 92 patients at the Gosport War Memorial Hospital in the late 1990s.

The inquests are being held into the death of Code A

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The other deaths are of Code A

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BBC NEWS

'Open mind' over hospital deaths

Hampshire's chief constable says he is keeping an "open mind" about reopening an inquiry into deaths at a hospital until he has seen the coroner's report.

An inquest jury looked into 10 deaths at the Gosport War Memorial Hospital in the late 1990s and found three were given "inappropriate medication".

Chief Constable Code A said there are no plans to reopen the case but he would look at the verdict.

Police looked into the treatment of 92 patients but no charges were brought.

Code A told BBC Radio Solent: "The first thing I would like to say is the families have clearly been through a dreadful experience and I have a great deal of sympathy for them."

'Reconsider position'

He said that during three police investigations hundreds of statements were taken and some of the most senior investigating officers were put on the case.

"The case was taken to the CPS (Crown Prosecution Service)... and the decision was there was nothing to prosecute in this case," Code A added.

"I have watched what has happened at the inquest and think some serious things have been said.

"What I have to look at very carefully is to see if anything new has come out of the inquest.

"At first glance these do appear to be the same issues as before which the CPS has made a decision on.

"I will wait for the coroner to produce his verdict in writing, I will very carefully read that verdict and if anything new emerges we will reconsider our position."

In recording a narrative verdict, the inquest jury also found that two patients were given the correct medication but in doses which contributed to their deaths.

Some of the relatives had long believed morphine was being over-prescribed.

The jury at Portsmouth Coroner's Court decided that in the cases of Code A Code A the use of painkillers was inappropriate for their condition.

Code A were prescribed medication appropriate for their condition but in doses which contributed to their deaths, jurors found.

In the cases of Code A the jury decided that the prescription of painkillers had not contributed to their deaths.

Dr Code A was investigated by police in connection with deaths at the hospital but she was not charged with any offence.

She said in a statement: "I can say that I have always acted with care, concern and compassion towards my patients."

Story from BBC NEWS:
http://news.bbc.co.uk/go/pr/fr/-/1/hi/england/hampshire/8009528.stm

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Code A

From: Code A
Sent: 21 April 2009 01:10
To: Code A
Subject: Report on Code A

Attachments: E - Code A .docx

Code A K.

Dear Code A

Please fine attached my last patient report.
I will work on finalising the Generic Report tomorrow.

Kind regards

Code A

THE INDEPENDENT

April 21, 2009

Morphine overdoses blamed for hospital patients' deaths

Jury rules high doses of the powerful painkiller had been prescribed 'without justification or logic'

An unprecedented inquest into the deaths of 10 elderly patients at a hospital in Portsmouth has concluded that three of them were wrongly prescribed excessive doses of morphine which hastened their end.

Two other patients were also prescribed drugs which contributed to their deaths – but the prescribing was appropriate for their condition, a jury found yesterday. The deaths of five other patients were not caused by the drugs they were taking, it said.

Yesterday's verdict follows a decade-long series of inquiries by police and the NHS into almost 100 deaths at Gosport War Memorial Hospital in the late 1990s.

Relatives of those who died had long claimed that morphine had been overprescribed. In a statement after yesterday's verdict , they said the jury's ruling showed high doses of the powerful painkiller had been given "without justification or logic" and they awaited the response of the General Medical Council.

Complaints about the hospital date back a decade. Families spoke of the "death ward" and claimed that patients were sent to the hospital to recuperate but had instead deteriorated and died. Staff responded by saying many of the patients were terminal and had been referred for palliative care.

Hampshire Police investigated but no action was taken. They alerted the Commission for Health Improvement, the NHS watchdog (now the Care Quality Commission), which concluded in 2002 that there had been a failure in patient care, with poor prescribing and supervision of staff, but that conditions had since improved. Publicity around that report led more families to come forward and Hampshire Police started another investigation.

Of 92 deaths, 10 sample cases were referred to the Crown Prosecution Service but it decided there was not enough evidence to prosecute. The cases were passed to the Portsmouth coroner who had to request special permission to hold inquests into the deaths from the Justice Secretary, Code A because seven of the 10 had been cremated. The law requires an inquest to be held in the presence of a body, save in exceptional circumstances.

Sir Code A the Government's Chief Medical Officer, ordered a review into death rates at the hospital in 2002 by Professor Code A , the expert who exposed the statistical pattern in the Shipman murders, but the results were not made public.

The jury in the month-long inquest, which concluded yesterday, found that three of the patients – Code A Code A and Code A – were prescribed medication that was not appropriate for their condition. However it was given for therapeutic reasons, implying that the overdose was not deliberate.

Professor Code A who examined the case of Code A who had died aged 74 after receiving treatment for a broken arm, told the inquest that he might have left hospital alive if he had not been put on morphine.

Code A, was being treated for a heart condition but staff failed to spot he was also suffering from internal bleeding. Professor Code A an expert in palliative care, told the inquest he was also given "excessive amounts" of morphine.

In the case of two other patients – Code A and Code A – the medication was appropriate and given for therapeutic reasons, the jury found.

Dr Code A a GP who worked at the community hospital part time, was the main doctor in charge of Dryad and Daedalus wards, where the patients died, and was the only member of staff investigated in relation to the deaths, though she never faced any charges. The inquest heard that she introduced a system of pre-emptive prescribing which allowed nurses to increase the amount of painkillers such as morphine without the need of a doctor being present.

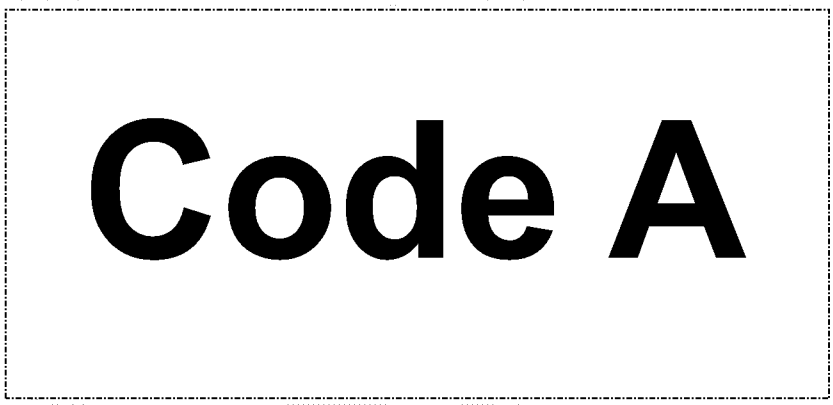
TIMESONLINE

From The Times

April 21, 2009

Gosport 'Death Ward' patients were over-prescribed painkillers

Families call for new criminal investigation



(PA)

(L-R) Code A

Code A

Five elderly patients who died at a hospital in Hampshire were overprescribed strong painkillers that hastened their deaths, a jury has said.

The ruling has prompted calls for a new criminal investigation.

Three of the patients whose deaths were investigated were given inappropriate drugs, the inquest at Portsmouth Coroner's Court said, raising fresh questions over the quality of their medical care.

The inquest jury of five women and three men looked at the deaths of ten patients at the Gosport War Memorial Hospital between 1996 and 1999. They were among 92 suspicious deaths at the hospital investigated by police, over which no charges were brought.

The jury concluded that in the cases of Code A the medication was unsuitable, but they said it had been given for therapeutic reasons. They also ruled that drugs had contributed to the deaths of two other patients – Code A and Code A Code A (known as Code A) – although in their case the jury said that it was appropriate for their condition.

In all five cases, the administration of medication "contributed more than minimally" to their deaths.

In the cases of Code A and Code A the jury decided that the prescription of painkillers had not contributed to their deaths.

The inquests, approved by Code A the Justice Secretary, followed a series of inquiries by the police and the NHS into almost a hundred deaths dating back to the late 1990s. Each of the ten patients was nearing the end of life and went to the community hospital for palliative care.

Diamorphine – a solution of morphine and saline – is used commonly to relieve the pain of dying patients. It also helps to reduce distress.

Prescription of strong painkillers is subject to specific guidelines, but the families said that their relatives had been overprescribed painkillers.

In a statement after the verdicts they also called for a fresh police investigation so that criminal charges could be brought against those responsible. However, a spokesman for Hampshire police indicated that they had no plans to carry out a new investigation. A police spokesman said: "Hampshire Constabulary has conducted three separate investigations, during which the Crown Prosecution Service has been fully consulted.

"It is our genuine hope that the extensive nature of the investigations conducted, the findings of the Crown Prosecution Service and now that of HM coroner provide those involved with some resolution, if not comfort, for the loss of loved ones."

Code A the primary doctor involved, gave evidence to the inquest, along with the patients' families, medical experts and staff at the hospital. She was the only individual to be investigated by police in connection with the deaths but was not charged with any offence. A GMC panel later ruled that she could work as a doctor only on condition that she stopped prescribing diamorphine and restricted her prescribing of Valium (diazepam). A spokeswoman for the medical regulator said that it was unlikely to reinvestigate Dr Code A unless the police took further action.

Code A from NHS Hampshire, apologised on behalf of the health service. "It is a matter of regret to the NHS that three verdicts indicate that in the mid to late 1990s the medication administered to these patients has been found to have contributed to their deaths", he said.

"Since the late 1990s the systems and policies in place at Gosport War Memorial Hospital have undergone a complete overhaul."

Telegraph.co.uk

Families call for fresh police investigation into Gosport hospital 'death ward'

Relatives of five patients who died on a hospital's "death ward" have called for a GP to be reinvestigated after an inquest jury decided excessive doses of morphine contributed to their deaths.

By Code A
Last Updated: 8:43AM BST 21 Apr 2009

The Gosport War Memorial Hospital in Gosport, Hampshire Photo: PA

Dr Code A who was the prescribing doctor in each case, was the subject of two lengthy police investigations into a total of 92 deaths which ended with the Crown Prosecution Service deciding there was insufficient evidence to charge her.

But after a 10-year campaign by families of the dead, an inquest in Portsmouth ruled that medication had been a factor in five deaths at the Gosport War Memorial Hospital between 1996 and 1999.

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Relatives believed that their loved ones had, in the words of one man, been "intentionally executed" at the hospital's Dryad and Daedalus wards.

The son of one elderly woman who died after being given an increased dose of diamorphine told the inquest that when he asked Dr Code A how long his mother was likely to be in the hospital, she replied: "Do you know your mother has come here to die?"

The inquest jury decided that Code A and Code A Code A were given medication which was not appropriate for their condition, and which contributed to their deaths, although it had been given for therapeutic reasons. They also

ruled that medication had contributed to the deaths of Code A and Code A Code A, but was appropriate for their condition.
Medication had not been a contributory factor in the deaths of five other patients whose deaths were examined at the inquest.
The inquest jury was not shown a report by Code A a professor of pharmacology at Newcastle University, who raised concerns that there may have been a "culture of voluntary euthanasia" on the wards.
Nor were they shown a report into allegedly abnormal death rates at the hospital written by Prof Richard Baker, who worked on the Harold Shipman inquiry, and whose findings have never been made public.
Some of the families believe there has been a "cover-up" by the NHS and demanded the CPS look again at the extensive evidence gathered by police.
Code A, whose father Code A died after telling his family doctors were "killing" him, said: "I feel absolutely ecstatic, and heartbroken at the same time, that my dad died knowing he was being killed. I will carry on now and make sure these people that are responsible for my father's death are brought to justice."
Code A a solicitor for three of the five families, said: "They feel vindicated by the verdicts and they believe the CPS should look again at the evidence. They don't see this as the end of the story."
Dr Code A is currently being investigated by the General Medical Council, which has imposed interim restrictions on her registration, including banning her from prescribing diamorphine.
The wards were nicknamed the "end of the line" locally because of its allegedly high death rates and suspicions of some families that loved ones who seemed to be in no immediate danger deteriorated rapidly after being admitted and often died within days.
Code A was admitted to Dryad ward in October 1998 after he suffered a broken arm. He also suffered from liver problems because of a long-standing drink problem and the cause of his death was given as heart and liver failure.
Code A told the inquest his father had made a good recovery at the Queen Alexandra Hospital in Portsmouth from the fall that broke his arm. But when he was transferred to Gosport, his condition deteriorated severely and he died four days later.
Code A said: "I went to give him a cuddle and he spoke his last words to me: 'Help me son, they are killing me.'
"I said 'No they are not Dad, they are trying to do the best for you' and I left him there. When I went in the following day, he was in a coma."
Prof Code A, of the University of Leicester's department of health and science, told the hearing: "The initiation of the diamorphine was inappropriate and the starting dose too high. Code A might have left the hospital alive if he had not been started on diamorphine."
Dr Code A who was the main doctor in charge of the two wards, said that many relatives had "unrealistic expectations" for the health of their loved ones as they arrived at GWMH.