Other Document Form

Number D1199

Title BRIEFING NOTE FOR STRATEGIC HEALTH AUTH MEETING 22/10/2004

(Include source and any document number if relevant)

Receivers instructions urgent action Yes / (No)

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

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Code A

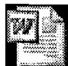
O/M	SIO

Indexer

Code A

From: Williams, David (DCI)
Sent: 29 October 2004 10:28
To: Code A
Subject: FW: Briefing note SHA etc 22.10.2004.

From: Williams, David (DCI)
Sent: 21 October 2004 16:08
To: Code A
Subject: Briefing note SHA etc 22.10.2004.



Briefing note SHA etc 22.10.20...

Dave.. As discussed.. Please feel free to add any other subjct areas appropriate..

Thanks.DW.

CONFIDENTIAL.

OP ROCHESTER briefing note in preparation for meeting with Strategic Health Authority and Fareham and Gosport Primary Care Trust Friday 22nd October 2004.

This will not be released as a document to meeting attendees.

Overview.

This investigation in essence followed allegations that during the 1990's elderly patients at the Gosport War Memorial Hospital received sub optimal or sub- standard care, in particular with regard to inappropriate drug regimes, and as a result their deaths were hastened through the administration of principally Diamorphine, Haloperidol (an Anti-Nausea sedative), Hyosine (an anti-spasmodic drug often prescribed during the treatment of Urine Disorder), and Oramorph (an oral morphine solution for pain relief.

The investigation brief was to establish a causal link between the administration of Code A and the death of GWMH patients.

The allegations followed reports from various 'experts' who had reported upon the demise of five particular patients within a previous investigation by the Hampshire Constabulary.

On the 9th November 2000 Professor Brian LIVESLY reporting on the death of patient Gladys RICHARDS stated ' Dr Jane BARTON prescribed drugs, Diamorphine, Haloperidol Midiazapam, Hyoscine, in a manner as to cause her death...As a result of being given these drugs Mrs. RICHARDS death occurred earlier than it would have done from natural causes'.

On the 12th February 2001 Professor FORD reported in respect of the deaths of five patients (RICHARDS, CUNNINGHAM, WILKIE, WILSON and PAGE) that these patients had been subjected to 'Inappropriate, reckless prescription of Opiate and sedative drugs.

On the 18th October 2001 Professor MUNDY reporting on the deaths of patients CUNNINGHAM, WILKIE, WILSON and PAGE commented ' That Morphine was started prematurely, that the levels of Diamorphine used were excessive and that no Analgesia was tried prior to Morphine, there was no documentation of pain being experienced by the patients.'

Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths, and concluded that, ' A number of factors contributed to a failure of trust systems to ensure good quality patient care'.

Between May 2002 and September 2002 Professor Richard BAKER on behalf of the Chief Medical Officer conducted a statistical analysis of mortality rates at the Gosport War Memorial Hospital. Whilst the rates were not statistically high nationally, Professor BAKER raised 'concerns' in relation to 16 particular cases all having input from Dr BARTON during the patient treatment regime.

The BAKER investigation at GWMH caused Staff Nurse Anita TUBBITT to report concerns regarding the use of syringe drivers to administer Diamorphine and increased mortality rates during 1991.

Between September 2002 and May 2004 issues were raised in respect of the deaths of 90 patients at the Gosport War Memorial Hospital. During 2003/4 these cases were fully reviewed by a team of experts in toxicology, general medicine, palliative care, geriatrics and nursing.

13 cases in total have been raised as falling within a 'Negligent care' status, that is to say 'care outside the bounds of acceptable clinical practice' 7 of these cases fall into a further category where 'causation or death and/harm is unclear.'

<u>Issues previously raised by Fareham and Gosport Primary Care Trust and the Strategic Health Authority.</u>

- Extent of ongoing investigations and timescales.
- What are the extent of/reason for police concerns?
- What are the patient's names and the number of cases the police are considering.
- What information can police disclose?
- Impact upon healthcare delivery and concerns of healthcare professionals.
- Ongoing media strategy.
- Civil litigation/health and safety executive issues.
- General Medical Council and Nursing and Midwifery Council position and ongoing liaison with the police. IOC hearing update?

<u>Issues to be raised by Police.</u>

- Media Strategy.
- Impact assessment.
- Potential outcome.
- Existing and ongoing arrangements for stakeholder updates.

1.Investigation Strategy.

90 cases reviewed by key clinical team of experts.

17 Category 1. Optimal Care. (Families have been informed NFA).

56Category 2. Sub Optimal Care. (19 families to date informed NFA. Remainder to be informed week commencing Monday 8th November)

13 Category 3. Negligent Care. (4x3a's where death of natural causes) 9 x 3b's, four of which subject to fast-track investigation, Elsie DEVINE, Elsie LAVENDER, Code A and Helena SERVICE). It is of note that 2 cases in this category have been previously considered by the GMC .I.O.C the case of Arthur CUNNINGHAM and Robert WILSON. No restriction upon Dr BARTON's registration being made during IOC hearings of 21st March 2002 and 19th September 2002.

All quality assured by Mathew LOHN of Field Fisher and Waterhouse.

2.Timescales.

First four cases assessed negligent. Subject to expert evidence being available it is the intention to interview Dr BARTON and any other healthcare professionals potentially liable.

Cases of sub-optimal care. Quality assurance and summaries will have been completed by Mathew LOHN week commencing Monday 8th November 2004.

3.Commissioning of Experts to provide evidential statements in respect of 3b's.

Geriatrician.

Expert in Palliative care.

4. Phase Four Investigation. The identity of these cases have not been directly revealed to Dr BARTON.

All of the 3b's involve Dr BARTON prescribing either rapidly escalating or high dose levels of Diamorphine prior to death often delivered through syringe driver.

1. Elsie DEVINE. Renal Failure. Syringe driver Diamorphine. Inappropriate prescription Fentanyl for pain relief.
2. Elsie LAVENDER. Head Injury/brain stem stroke. Large dose escalation from Morphine to Diamorphine. May have contributed towards death.
3. Code A Deteriorating mental health. Frail. Syringe driver Diamorphine.
4. Helena SERVICE. Diabetes/Heart problems. Diamorphine/syringe driver sedation. Medication could have contributed towards death.

DEVINE statementing complete.
Case of Code A Relatively straightforward, approx 12 healthcare professionals only involved in his care.

5. Exhumation.

Four of the 3B cases have been buried.

- Elsie DEVINE.
- Elsie LAVENDER.
- Sheila GREGORY.
- Jean STEVENS.

6.Other key Stakeholder Contact.

- Chief Medical officer
- Crown Prosecution service.
- HM Coroner David HORSLEY.
- General Medical Council.
- Family group solicitors Anne ALEXANDER.
- Solicitor for Dr BARTON. Ian BARKER.

7.Conditions currently agreed by Dr BARTON in relation to prescription of Opiates and Benzodiazepines.

As confirmed by Hazel BAGSHAW Pharmaceutical Advisor to the Fareham and Gosport Primary Healthcare Trust 5.7.2004.

'Dr BARTON has undertaken not to prescribe benzodiazepines or opiate analgesics from 1st October 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.

Dr BARTON will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health-call as a prescription may be required for a 14 day supply of Benzodiazepines for bereavement.

Dr BARTON has also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patients notes.'

During a 13month periods from April 2003 Dr BARTON had written a total of 20 prescriptions all for 2mg diazepam to relatives of deceased and had not prescribed any diamorphine, morphine or other controlled drug.'

DW.
22.10.2004.