Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Tel: 01329 233447
Fax: 01329 234984

Ref IP/jkf/L 7 8

Code A

7 August 2002

Dear Code A

Gosport War Memorial Hospital - CHI Report

Thank you for your letter dated July 19th 2002.

I look forward to hearing from you once you have written to the Commission for Health Improvement.

Code A

Ian Piper
Chief Executive

Code A

Date: Friday 19th July 2002

T
Wor
Email Home:
Email work:
Code A

Mr. Ian Piper
Chief Executive
Fareham and Gosport Primary Care Trust
Unit 180
Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Your Ref.: IP/jkf/L 18 7

1948 earliest date

Dear Mr. Piper,

RE: GOSPORT WAR MEMORIAL HOSPITAL – CHI REPORT

Thank you for your letter and I welcome the opportunity to be involved in any process that may improve the situation that obviously existed in 1998/9.

I do have a number of specific questions and queries regarding the report and I am at present in the process of replying to the Commission for Health Improvement to clarify some of these. One of these questions was that the CHI report fails to mention death figures, although it does mention a high number of "Finished Consultant Episodes". I am asking CHI exactly what this term means in relation to those that died.

I will in due course reply in full to your letter, but one question that I will be asking in respect of death figures of the hospital will be: Are you able to provide death figures for the hospital from 1990 to 2001?

Fiona? Is this possible??

Yours sincerely,

Code A

Lucy
do you have the original letter.

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Primary Care Trust

Unit 180, Fareham Reach
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Tel: 01329 233447
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Direct Line: Direct Fax: Code A

23 May 2002

Our Ref: IP/VB/L2305-01

Code A

Dear Code A

Gosport War Memorial Hospital
(Investigation of deaths – Mrs El Page)

Thank you for taking the opportunity to meet with Code A and myself on May 17th and for clarifying your concerns regarding the care provided to your late mother at Gosport War Memorial Hospital and for your letter dated May 17th 2002.

There are a few points of clarity I would like to make in relation to your letter.

As with all NHS hospitals the responsibility for managing staff and standards of care lies with the staff member's employer. Since April 2002 hospital medical and nursing staff who work on the Elderly Medicine wards at Queen Alexandra Hospital and the medical staff who work on Dryad and Daeadalus wards at Gosport have been employed by East Hampshire Primary Care Trust. Nursing staff on these Gosport War Memorial wards are employed by Fareham and Gosport PCT. Both PCT's have been working closely with each other and whilst this appears to be a complex system the accountability of employing organisations is very clear.

Regarding the Police Reports I can restate that as an organisation we would be happy for these reports to be available to the families, however our legal advice is that we are unable to release the reports as they do not belong to us. This is an issue I know you have taken up with police. I would also like to clarify that the PCT has not made these reports generally available within the PCT or Gosport hospital.

I think it is important to distinguish between criminal action which needs to be investigated by the police and clinical care which does not meet the standards expected by patients and carers which needs to be investigated initally by NHS organisations. This issue you raised of "unlawful euthanasia" at the hospital is a criminal charge and one which has been investigated by the police and on the basis of these investigations the Crown Prosecution Service have decided not to proceed with a prosecution. The police have also decided not to conduct further criminal investigations into more cases. I am aware that you are dissatisfied with the decisions and that you have contacted the police expressing your dissatisfaction.

The issues raised by yourself and the other families have identified areas where the quality of clinical care can be improved and a number of changes have been made to improve standards at Gosport. The PCT is looking forward to the publication of the Commission for Health Improvement investigation report in early July 2002 as it will reach conclusions regarding the current quality of care at the hospital and make recommendations for action. This PCT will be the responsible organisation for developing an action plan and implementing the recommendations.

I hope that the publication of the independent report and the implementation of an action plan will play a major part in restoring the public's confidence in the hospital.

With regard to your final three points you are correct in saying that these are the actions you would like the PCT to take but they were not actions we agreed to undertake, but agreed to consider.

I have however written to the three other families whose relative's notes were reviewed by the Police asking for their permission to give you their names.

As stated previously the PCT would like to release the police reports but having taken legal advice has no powers to do so.

The staff at the hospital have in the past 3 years fully co-operated with two police investigations; a health service ombudsman's review; and independent complaints enquiry and the most recent Chi investigation. I hope that when the Chi report is published and the action plan developed and implemented this will go a long way to re-establishing the confidence of local people in Gosport Hospital.

Code A and I appreciate how difficult and distressing it must be for you at the moment and we wish to assure you that the PCT will do all in it power to ensure the recommendations of the Chi report are implemented.

Code A

Ian Piper
Chief Executive

G:\Team Secretary\CEO IP\Letters\L2305-01.doc.dot

Code A

Date: Friday 17th May 2002

Mr. Ian Piper
Chief Executive
Fareham and Gosport Primary Care Trust
Unit 180
Fareham Reach
166 Fareham Road
Gosport
PO13 OFH

Dear Mr. Piper and Mrs. Docherty,

RE: GOSPORT WAR MEMORIAL HOSPITAL
INVESTIGATION OF DEATHS – DEATH OF MRS E.I.PAGE

I would like to thank you for enabling me to convey my concerns at our meeting today. I appreciated your initial comment in your letter of the 10th May, that we have an open and honest dialogue to clarify the issues of concern and I feel this was achieved. I would now like to take this opportunity to confirm in writing the points discussed.

I understand that you have the responsibility of ensuring that GWMH functions in a professional and safe manner, for the confidence of its local population. It was of concern to me that you have no control in other hospital (QAH or Southampton) where patients would be transferred. I also raised concern that you do not have control over all your staff; you mentioned some staff relating to Geriatrics. There is also the problem of doctors and perhaps other staff who work in GWMH and other hospitals. Dr Lord for example was responsible for my mother's care in both QAH and GWMH, if that is the case now you have no control over her actions whilst she is working in QAH.

During the early stages of our meeting it became clear that you were in possession of all the relevant documents appertaining to the Serious Crimes Investigation to your hospital, which has been halted. You stated that you had no objection to me having these reports, and you also felt it unfair that everyone involved in the enquiry, including staff and management at GWMH, have access to these reports **except** the Next of Kin of the those who died and whose deaths are still of great concern. You agreed to investigate further to see if you are able to release these reports to me.

You agreed that the practices and in effect the management (staffing levels etc) of the hospital at the time of my mother's death was unsatisfactory. I understand that you have initiated and installed many procedures, plans, training and documents to support a change in the management of this hospital.

I explained that I had examined my mother's medical notes, and had them viewed by another medical qualified professional. Our interpretation of the medical and nursing staff reports and drug records show many areas of grave concern in the treatment she received. No firm diagnosis was ever made; her routine daily medication was suddenly stopped; opiates used when the notes clearly show my mother was not in pain; drugs administered which were not only contra indicated but should only have been used under a Consultant Specialist's supervision; simple measures early on like solving her nausea although prescribed was never given.......I could go on.

When I suggested that there is a culture within the hospital that is operating an unlawful euthanasia system with certain patients you naturally felt I was wrong, and that the changes you have made should give me confidence in the hospital. I explained that I, and all the other relatives of patients who have died whilst in the care of the medical and nursing staff of your hospital will be unable to accept that conditions and attitudes have changed whilst you still continue to employ the same staff mentioned in these highly critical investigation reports. I agreed that terminating their employment cannot be performed without just cause, and for that reason I feel you should support our request that this police enquiry into the deaths continue. The local population is aware that all is not well in your hospital; more individuals are coming forward with their own concerns relating to the care their relatives received.

You asked what you the PCT can do to give me confidence in the new management of the hospital, we agreed on the following three points:

1. That you would release the names of the four patients spearheading the police investigations.

2. That you release all the police reports including the medical reports, which were highly critical of the care of these patients.

3. That you publicly and openly endorse our efforts to have the police enquiry reinstated to enable a full investigation of all the patients that died in the period we discussed.

Finally may I again emphasize the point that I made, that you are responsible for a hospital that employs staff that are already under a cloud. Unless you support an open and honest investigation into the events you will never get the support of the people in Gosport who matter.

Thank you again for the meeting.

Code A

Code A

(1998) →

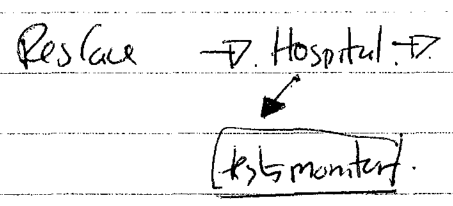
Code A . 88.
PCT .

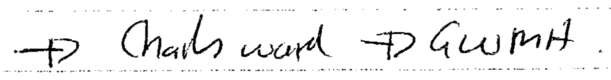
Staff resp for ~~Bo~~ (PHT)

Issues
1) ChI investigation not looked at specifics staff individuals.
2) Issues.

- manslaughter allegations
- feel wanted to kill your mother: all DrL.
- Charles ward QAH . (Stopped Drugs for Heart condition incl pain relief prior to transfer:
- no blood tests etc: - ⊛ opinion on X ray - cancer of the lung!!
- "not in pain" - ↓ palliative care
-
- pain relief was opiates. 3 stg since 1995
-

ResCare → Hospital → → Charles ward → GWMH .





1) was there a confirmed Diagnosis of Lung cancer.

- move for GWMH ? Sedated on arrival @ GWMH → told we never had an opp to talk to her.

- "move to GWMH" - ?? cld not talk with carer?? →

- will be making an official complaint . not yet.

-

overall 4. → went to the Police _ Concern re rapid deterioration
- mention at the time (notes)
- Drugs (pain).

when realised you were not the one $ 2001 → police →
reply Jan 2002. (Police officer to give reports) ⊛

police reports included manslaughter (so police say).
officer reports to police but police then said no !! –

Court order

→ Investigation reopened.

→ had or have:

Chi

◊ PTT to reopen enquiries

◊ Chi

ISSUES

meeting → decision not to proceed further after 4 weeks

CPS

* not aware the names: If we can we will !!

Medical Reports

our absolute commitment to get to the bottom

anonymised

Access to Police Reports

It was homicide??

legal opinion

→ lead people to know !!

not new.

Shipman enquiries - investigs A police

Dr's Abuse of power + culture - do what you like!!

Investigations not good enough / not [illegible] !!!

not happening now

you want a full police investigation into criminal acts!!

better way to take your evidence:

we owe families a debt

You want the PCT to ask for another investigation.

In your view the notes are clear

only way to restore confidence.

Clear on issue — Raise it.

- see police reports / medical opinion!
- Full + complete ~~TRUE~~ police investigation into all deaths
- ~~[illegible]~~ ~~Culture~~ "Suppose MRS M" i.e. police worse?
- Name of other 3 cases. police

~~why diamorphine / [illegible] / closed institution / self protection /~~

~~[illegible] [illegible]~~ ~~[illegible] [illegible]~~

attack

experts in